

11167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1655 E. Cold Spring Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wayne Middle Elbert Last Batton				4. DATE OF DEATH Month October Day 16 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1920	
9. AGE (In years last birthday) 38 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fleming Fielding Batton		14. MOTHER'S MAIDEN NAME Blancha Margaret Perry		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) no	
16. SOCIAL SECURITY NO. 233-12-7177		17. INFORMANT Springfield Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leenec's cirrhosis. 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ABS associated with alcoholism plus CBS associated with alcoholism		INTERVAL BETWEEN ONSET AND DEATH month	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield State Hospital		(County) (State)	
21. I certify that I attended the deceased from September 27, 1958 , to October 16, 1958 , that I last saw the deceased alive on October 16, 1958 , and that death occurred at 11:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/16/58							
ACTUAL SIGNATURE Agustin del Campo M.D.				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/19/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cem.	
22d. LOCATION (City, town, or county) West Virginia				22e. REC'D BY REGISTRAR Arthur L. Howard		22f. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

11168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester #1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Clinton</u> Middle <u>H</u> Last <u>Baughman</u>		4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-1882</u>
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired from Carroll Co. - farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Georg Baughman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1213-18-8604</u>	
17. INFORMANT <u>Carl C. Baughman</u>		Address <u>Manchester #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 4</u> , 19 <u>58</u> , to <u>Oct 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 25</u> , 19 <u>58</u> , and that death occurred at <u>3:4</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foad</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Manchester Md 10-27-58</u>	
PHYSICIAN'S NAME (Type) <u>W H Foad M.D.</u>			
22a. REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. David's German Lutheran Fg Rd York Co.</u>	22d. LOCATION (City, town, or county) (State) <u>York Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucher</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Signature of informant: _____

13. Date of filing: _____

14. File number: _____

15. Registrar's office: _____

16. County: _____

17. State: _____

18. City: _____

19. Zip: _____

20. Telephone: _____

21. Address: _____

22. Name: _____

23. Title: _____

24. Signature: _____

25. Date: _____

26. File number: _____

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619. Zip: _____

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622. Name: _____

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726. City: _____

727. Zip: _____

728. Telephone: _____

729. Address: _____

730. Name: _____

731. Title: _____

732. Signature: _____

733. Date: _____

734. File number: _____

735. Registrar's office: _____

736. County: _____

737. State: _____

738. City: _____

739. Zip: _____

740. Telephone: _____

741. Address: _____

742. Name: _____

743. Title: _____

744. Signature: _____

745. Date: _____

746. File number: _____

747. Registrar's office: _____

748. County: _____

749. State: _____

750. City: _____

751. Zip: _____

752. Telephone: _____

753. Address: _____

754. Name: _____

755. Title: _____

756. Signature: _____

757. Date: _____

758. File number: _____

759. Registrar's office: _____

760. County: _____

761. State: _____

762. City: _____

763. Zip: _____

764. Telephone: _____

765. Address: _____

766. Name: _____

767. Title: _____

768. Signature: _____

769. Date: _____

770. File number: _____

771. Registrar's office: _____

772. County: _____

773. State: _____

774. City: _____

775. Zip: _____

776. Telephone: _____

777. Address: _____

778. Name: _____

779. Title: _____

780. Signature: _____

781. Date: _____

782. File number: _____

783. Registrar's office: _____

784. County: _____

785. State: _____

786. City: _____

787. Zip: _____

788. Telephone: _____

789. Address: _____

790. Name: _____

791. Title: _____

792. Signature: _____

793. Date: _____

794. File number: _____

795. Registrar's office: _____

796. County: _____

797. State: _____

798. City: _____

799. Zip: _____

800. Telephone: _____

801. Address: _____

802. Name: _____

803. Title: _____

804. Signature: _____

805. Date: _____

806. File number: _____

807. Registrar's office: _____

808. County: _____

809. State: _____

810. City: _____

811. Zip: _____

812. Telephone: _____

813. Address: _____

814. Name: _____

815. Title: _____

816. Signature: _____

817. Date: _____

818. File number: _____

819. Registrar's office: _____

820. County: _____

821. State: _____

822. City: _____

823. Zip: _____

824. Telephone: _____

825. Address: _____

826. Name: _____

827. Title: _____

828. Signature: _____

829. Date: _____

830. File number: _____

831. Registrar's office: _____

832. County: _____

833. State: _____

834. City: _____

835. Zip: _____

836. Telephone: _____

837. Address: _____

838. Name: _____

839. Title: _____

840. Signature: _____

841. Date: _____

842. File number: _____

843. Registrar's office: _____

844. County: _____

845. State: _____

846. City: _____

847. Zip: _____

848. Telephone: _____

849. Address: _____

850. Name: _____

851. Title: _____

852. Signature: _____

853. Date: _____

854. File number: _____

855. Registrar's office: _____

856. County: _____

857. State: _____

858. City: _____

859. Zip: _____

860. Telephone: _____

861. Address: _____

862. Name: _____

863. Title: _____

864. Signature: _____

865. Date: _____

866. File number: _____

867. Registrar's office: _____

868. County: _____

869. State: _____

870. City: _____

871. Zip: _____

872. Telephone: _____

873. Address: _____

874. Name: _____

875. Title: _____

876. Signature: _____

877. Date: _____

878. File number: _____

879. Registrar's office: _____

880. County: _____

881. State: _____

882. City: _____

883. Zip: _____

884. Telephone: _____

885. Address: _____

886. Name: _____

887. Title: _____

888. Signature: _____

889. Date: _____

890. File number: _____

891. Registrar's office: _____

892. County: _____

893. State: _____

894. City: _____

895. Zip: _____

896. Telephone: _____

897. Address: _____

898. Name: _____

899. Title: _____

900. Signature: _____

901. Date: _____

902. File number: _____

903. Registrar's office: _____

904. County: _____

905. State: _____

906. City: _____

907. Zip: _____

908. Telephone: _____

909. Address: _____

910. Name: _____

911. Title: _____

912. Signature: _____

913. Date: _____

914. File number: _____

915. Registrar's office: _____

916. County: _____

917. State: _____

918. City: _____

919. Zip: _____

920. Telephone: _____

921. Address: _____

922. Name: _____

923. Title: _____

924. Signature: _____

925. Date: _____

926. File number: _____

927. Registrar's office: _____

928. County: _____

929. State: _____

930. City: _____

931. Zip: _____

932. Telephone: _____

9

11156

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Mills		c. LENGTH OF STAY IN 1b 9 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow View Convelescent Home		d. STREET ADDRESS 1 173 W. Main Street	
3. NAME OF DECEASED (Type or print) First Effie Middle Elizabeth Last Belt		4. DATE OF DEATH Month October Day 15, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1869
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.	IF UNDER 24 HRS. Months 8 Days 8 Hours 8 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles M. Hess	
14. MOTHER'S MAIDEN NAME Elizabeth Bushey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. M. Ross Fair, Taneytown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hepatitis (Secondary) DUE TO (c) Chronic Hepatocarcinoma		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 6 yrs. 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15/58 to 10/15/58 that I last saw the deceased alive on 10/15/58 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Arthur B. Bare		M.D. Arthur B. Bare 10/17/58	
PHYSICIAN'S NAME (Type) Dr. L. O. Bare			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 18, 1958	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son, Taneytown, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE OCT 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

Decedent

Married

Age

Sex

Place of Birth

Residence

Date of Death

Time of Death

Place of Death

Signature

Witness

Physician

Coroner

Signature of Coroner

Signature of Physician

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

1

11170

11157

Reg. Dist. No.

15

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

11170

CERTIFICATE OF DEATH

Reg. Dist. No.

11157

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN TB 1 mo. 29 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 28 d. STREET ADDRESS 3 N. Beechwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Elizabeth Blacklock				4. DATE OF DEATH Month Day Year October 24, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1872	
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Missionary		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allan R. Blacklock				14. MOTHER'S MAIDEN NAME Jane Chambers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-32-6456		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 420.0 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 25, 19 58 , to October 24, 19 58 , that I last saw the deceased alive on October 24, 19 58 , and that death occurred at 2:00a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				DATE SIGNED 10/24/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-58		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. ...				24a. REC'D BY REGISTRAR DATE OCT 31 '58		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Disease		Occupation	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Burial		Time of Burial		Place of Burial	
Name of Burial Place		Name of Minister		Name of Undertaker	
Name of Family		Name of Friends		Name of Neighbors	
Name of Clergy		Name of Musician		Name of Flowers	
Name of Casket		Name of Coffin		Name of Shroud	
Name of Pall		Name of Veil		Name of Hat	
Name of Shoes		Name of Gloves		Name of Socks	
Name of Undershirt		Name of Underpants		Name of Suspenders	
Name of Necktie		Name of Pocket Square		Name of Handkerchief	
Name of Wallet		Name of Keys		Name of Watch	
Name of Ring		Name of Earrings		Name of Bracelet	
Name of Necklace		Name of Scarf		Name of Hatband	
Name of Cufflinks		Name of Button		Name of Zipper	
Name of Locket		Name of Brooch		Name of Pin	
Name of Ribbon		Name of Thread		Name of Needle	
Name of Scissors		Name of Sewing Machine		Name of Iron	
Name of Stove		Name of Refrigerator		Name of Washing Machine	
Name of Dryer		Name of Vacuum		Name of Carpet	
Name of Rugs		Name of Curtains		Name of Drapes	
Name of Blinds		Name of Shutters		Name of Doors	
Name of Windows		Name of Roofs		Name of Siding	
Name of Foundation		Name of Basement		Name of Attic	
Name of Porch		Name of Deck		Name of Fences	
Name of Driveway		Name of Garage		Name of Barn	
Name of Shed		Name of Outbuilding		Name of Well	
Name of Septic Tank		Name of Sump Pump		Name of Water Heater	
Name of Air Conditioner		Name of Furnace		Name of Boiler	
Name of Radiator		Name of Stovepipe		Name of Chimney	
Name of Flue		Name of Vent		Name of Exhaust	
Name of Drain		Name of Sewer		Name of Storm Drain	
Name of Gutter		Name of Downspout		Name of Foundation	
Name of Sill		Name of Lintel		Name of Header	
Name of Stud		Name of Joist		Name of Rafter	
Name of Truss		Name of Beam		Name of Column	
Name of Post		Name of Pier		Name of Wall	
Name of Ceiling		Name of Floor		Name of Foundation	
Name of Siding		Name of Shingles		Name of Asphalt	
Name of Concrete		Name of Brick		Name of Stone	
Name of Mortar		Name of Grout		Name of Sealant	
Name of Paint		Name of Primer		Name of Varnish	
Name of Stain		Name of Wax		Name of Polish	
Name of Oil		Name of Grease		Name of Lubricant	
Name of Antiseptic		Name of Disinfectant		Name of Sterilant	
Name of Anesthetic		Name of Sedative		Name of Painkiller	
Name of Antibiotic		Name of Antifungal		Name of Antiviral	
Name of Antiparasitic		Name of Anticancer		Name of Anticoagulant	
Name of Antidepressant		Name of Antipsychotic		Name of Anticonvulsant	
Name of Antiepileptic		Name of Antihypertensive		Name of Antidiabetic	
Name of Anticholinergic		Name of Anticholesterol		Name of Anticardiac	
Name of Anticancer		Name of Anticancer		Name of Anticancer	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, ONE 10

11171

CERTIFICATE OF DEATH

11158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18, Md.			
c. LENGTH OF STAY IN 1b ly 2 m 9 d				d. STREET ADDRESS 2714 Guilford Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Archie Middle Nataniel Last Bowen				4. DATE OF DEATH Month 10 Day 3 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-18-198	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unkn				10b. KIND OF BUSINESS OR INDUSTRY Seaman		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Arthur Bowen				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unkn		17. INFORMANT S.S. Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circulatory disturbance with cerebral arterioscler. with psych. reaction. Pulm. tuberculosis mod. advanced, inactive				INTERVAL BETWEEN ONSET AND DEATH years			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-24-1958 to 10-3-1958 that I last saw the deceased alive on 10-3-1958 and that death occurred at 11:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-4-58 ACTUAL SIGNATURE Edmund Lusthaus PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.				ADDRESS 715 Light St.		24a. REC'D BY REGISTRAR DATE OCT 8 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

CERTIFICATE OF DEATH

Decedent's Name _____		Date of Death _____	
Sex _____		Race _____	
Date of Birth _____		Place of Birth _____	
Usual Residence _____		Place of Death _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

11-10-08

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

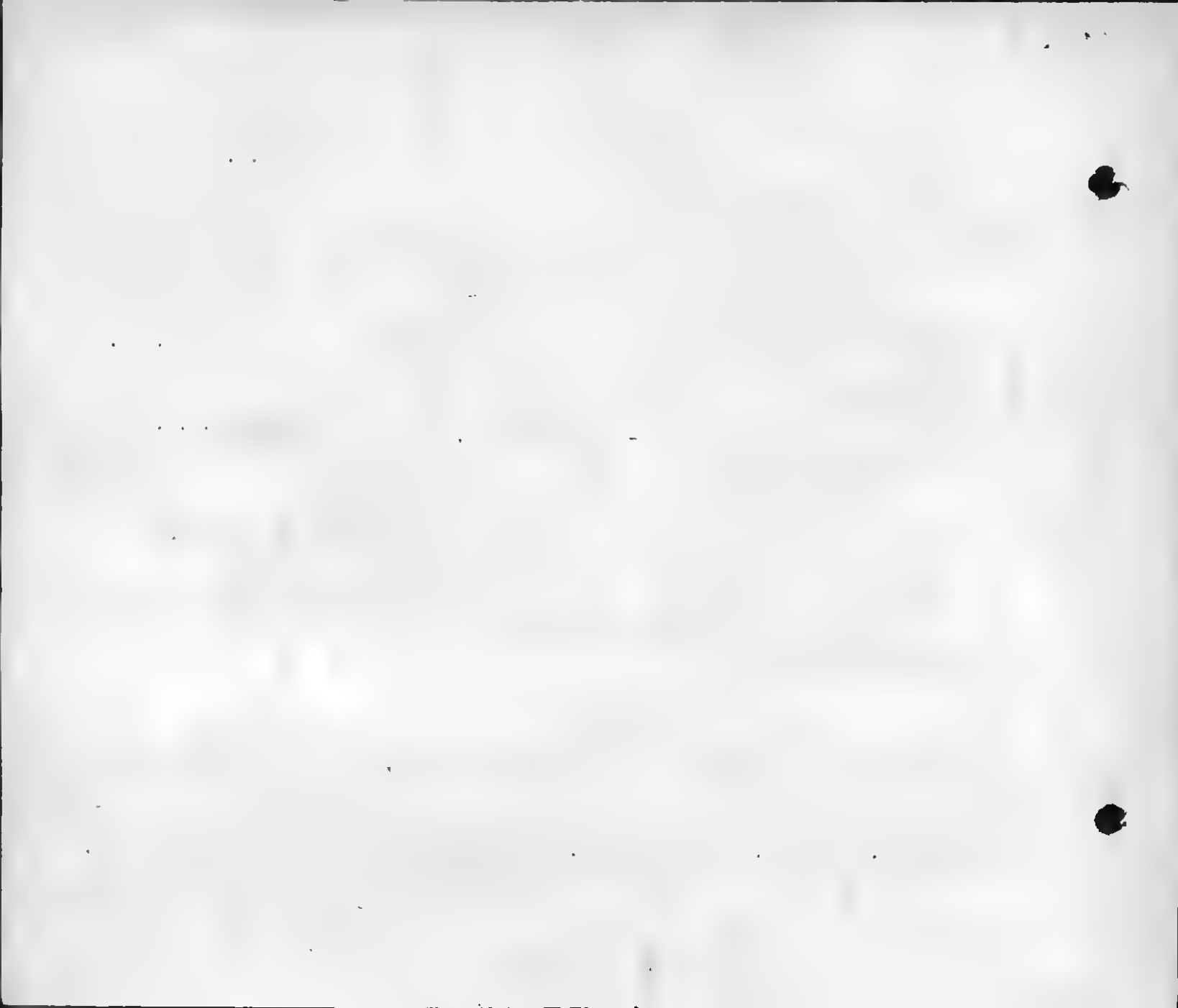
11172

CERTIFICATE OF DEATH

11159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 91 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood Route 2, P.O.		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Alexander Last Butler		4. DATE OF DEATH Month October Day 1 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-06
9. AGE (In years last birthday) 51 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Butler		14. MOTHER'S MAIDEN NAME Maggie Savoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 213-004-0574	
17. INFORMANT William A. Butler		Address Route #2, P.O. Anne Arundel Harwood, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced bilateral cavitory pulmonary Tbc. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2 , 19 58 , to October 1 , 19 58 , that I last saw the deceased alive on October 1 , 19 58 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 10-1-58 ACTUAL SIGNATURE E. M. Maculans M.D. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		10-8-58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Chews Chapel		A.A. Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE M. Rose		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DATE 10-1-58		24b. REGISTRAR'S SIGNATURE Oct 7 '58	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11173

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5yrs. 2mos. 14days Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 5609 Roosevelt St.	
3. NAME OF DECEASED (Type or print) Jane Baird Patterson		4. DATE OF DEATH October 16, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1881
9. AGE (in years last birthday) 77 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Patterson		14. MOTHER'S MAIDEN NAME Agnes Muir	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerosis (c) Due to the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/20/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Shutts Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		ADDRESS 24a REC'D BY REGISTRAR OCT 20 58	
		24b REGISTRAR'S SIGNATURE Curtis J. Marsh	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11161

Item 9 Film 235 11-3-58 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

THIS COPY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN 1b <u>25 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>#10 WILLOW AVE.</u> * IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>MONTROSE</u> Middle <u>CHEW</u> Last				4. DATE OF DEATH Month <u>10</u> / Day <u>21</u> / Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 4, 1901</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>57 5/8</u> yrs IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WESTERN MARYLAND RAILROAD EMPLOYEE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FINKSBURG MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES CHEW</u>				14. MOTHER'S MAIDEN NAME <u>FANNY B. CHEW nee??</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>WET SEPT. 1919 - SEPT. 1921</u>				16. SOCIAL SECURITY NO <u>216-03-2978</u>		17. INFORMANT Address <u>WIFE - MRS. MARK L. CHEW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushed chest & Internal Injuries</u> DUE TO <u>816 X</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET OF DEATH <u>minutes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Ran into Car into Rear end of Tractor Trailer</u>			
20c. TIME OF INJURY Month, Day, Year <u>8</u> Hour <u>—</u> <u>10/21/58</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. Route 140</u>		20f. (City or town) (County) (State) <u>Westminster, Carroll Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>acting</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>10/21/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHELL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEESE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jama G. Saffell</u> ADDRESS <u>258 E. Main St. Westminster Md</u>				24a. REC'D BY REGISTRAR <u>DOCT 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Clifton B. Travis</u>	



11162

CERTIFICATE OF DEATH

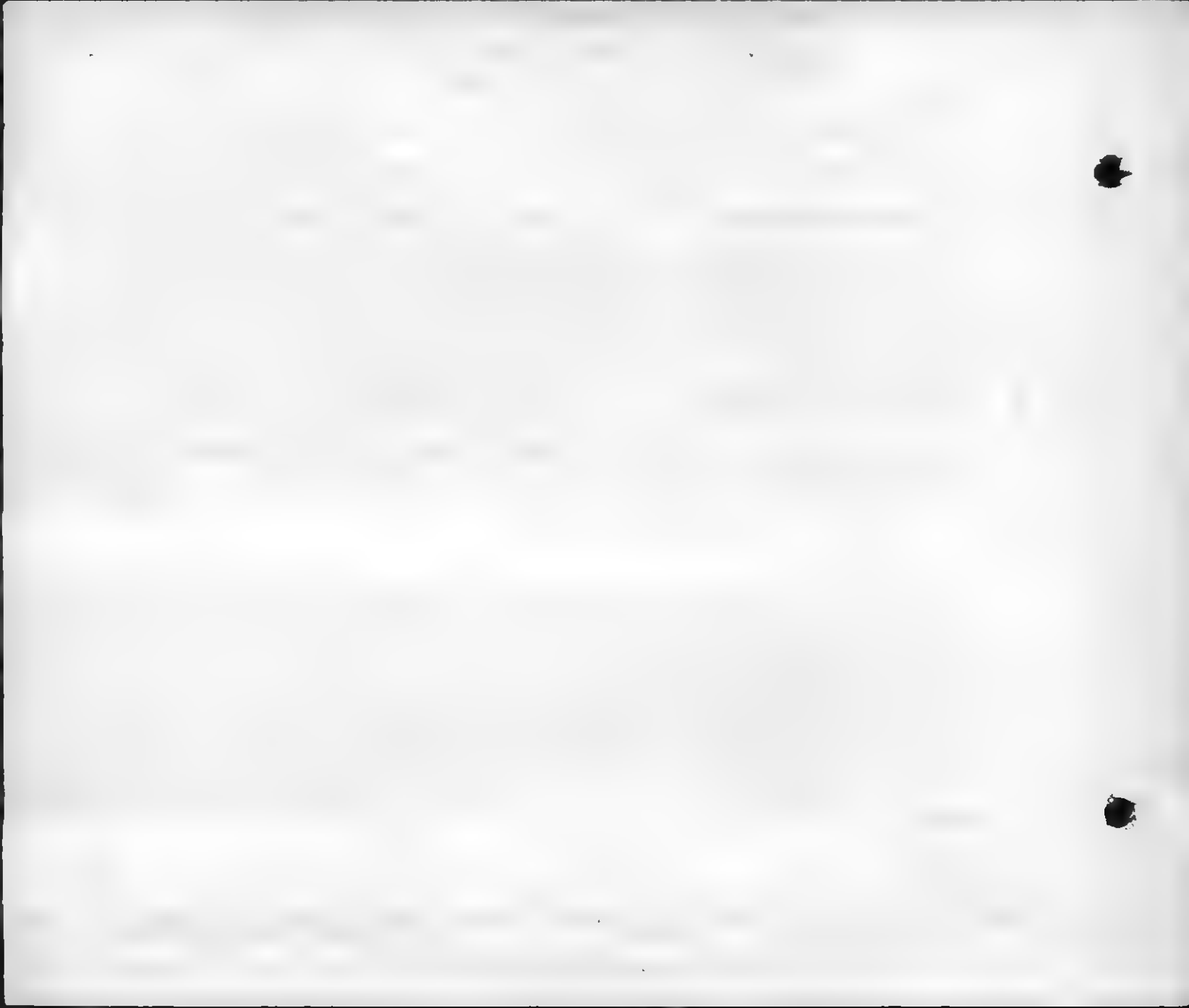
11162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Penna. Ave				d. STREET ADDRESS 204 Penna. Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JESSE FRANCIS CHREST				4. DATE OF DEATH OCT. 18 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15 1878	
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH, self employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WESTMINSTER, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE A. CHREST				14. MOTHER'S MAIDEN NAME MARGARET J. FOWLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT MISS LILLIAN L. CHREST, WESTMINSTER, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 1 month from onset	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 1948 to Oct 18-58 , that I last saw the deceased alive on Oct 18-58 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Wm. C. Jernette M.D. 103 E. Main Westminster, Md.							
PHYSICIAN'S NAME (Type) Wm. C. Jernette M.D. Westminster, Md.							
22a. BURIAL, CREMATION, OR MOVING (Specify) BURIAL		22b. DATE THEREOF OCT. 22, 58		22c. NAME OF CEMETERY OR CREMATORY LEISTER'S CEMETERY		22d. LOCATION (City, town, or county) (State) RURAL, WESTMINSTER, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr. Westminster, Md.				24a. REC'D BY REGISTRAR DATE OCT 22 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11174

CERTIFICATE OF DEATH

11163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>		d. STREET ADDRESS <u>East Main</u>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Christner</u> Last <u>Christner</u>		4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1866</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wheelwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carriage Maker</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Christner</u>		14. MOTHER'S MAIDEN NAME <u>Susan Cadoni</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Wayde Christner</u> Address <u>Bel Air Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Left Femur</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall out of Bed on Left Hip - 9/21/58</u>	
20c. TIME OF INJURY Hour <u>10</u> p. m. Month <u>9-21-1958</u> Day <u>21</u> Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>	20f. (City or town) <u>Manchester</u> (County) <u>Carroll</u> (State) <u>MD</u>
21. I certify that I attended the deceased from <u>June 12</u> , 19 <u>56</u> , to <u>October 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 7</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>10-9-58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>HAMPSTEAD Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 11, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Catholic</u>	22d. LOCATION (City, town, or county) <u>Emmitsburg, Frederick Co.</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. L. Allison</u>		ADDRESS <u>Emmitsburg, Md.</u>	24a. REC'D BY REGISTRAR <u>Oct 14 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

S. L. Allison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

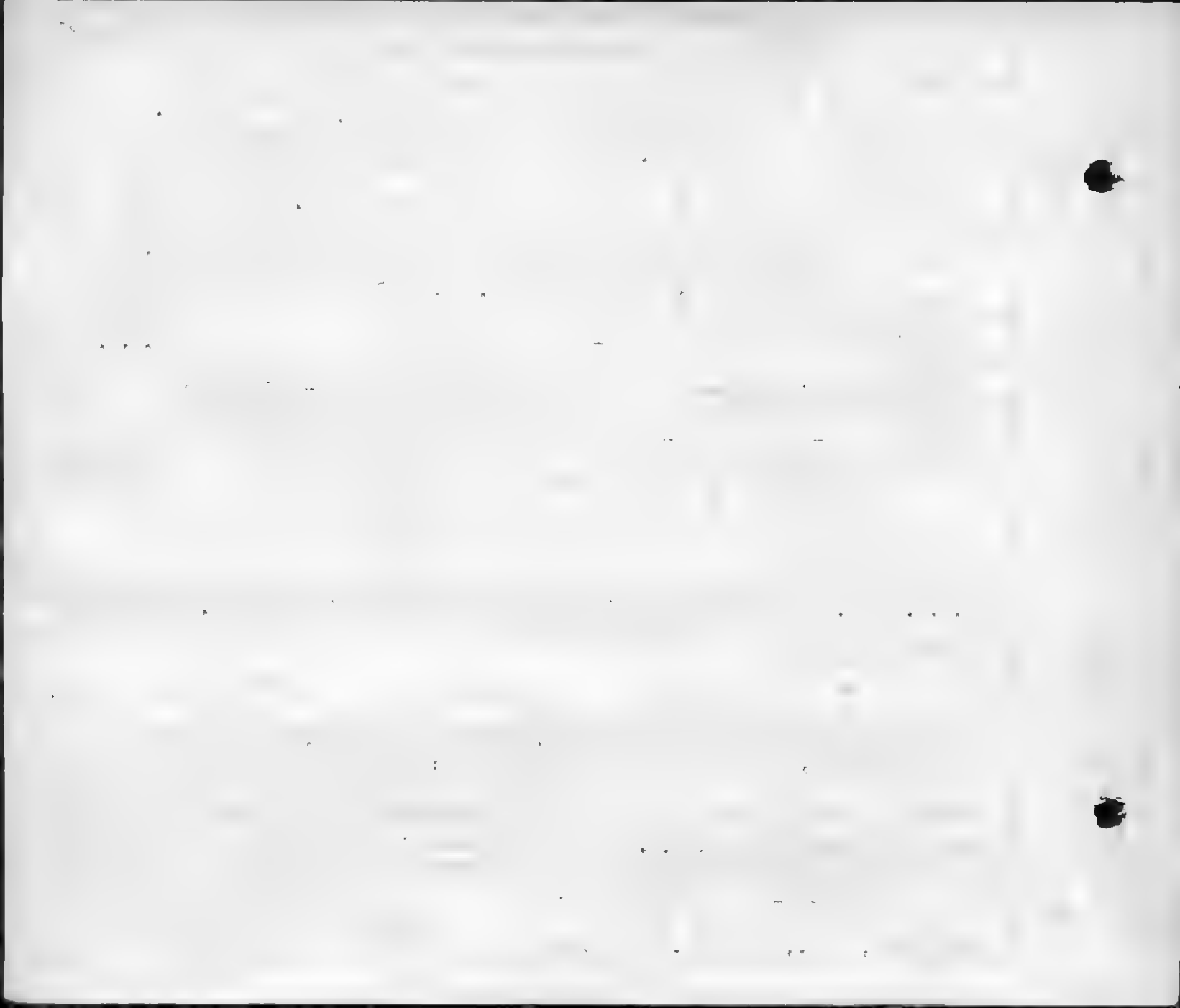
11175

CERTIFICATE OF DEATH

11164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6mos. 10days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3438 Elmora Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Ida Grace Thompson Davey				4. DATE OF DEATH Month Day Year October 7, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1871	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Thompson Wheeler				14. MOTHER'S MAIDEN NAME Laura Josephine Mackheimer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No -				16. SOCIAL SECURITY NO -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease							
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 27, 1958 , to October 7, 1958 , that I last saw the deceased alive on October 7, 1958 , and that death occurred at 7:45P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				DATE SIGNED 10/8/58			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-10-58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraws	



CERTIFICATE OF DEATH

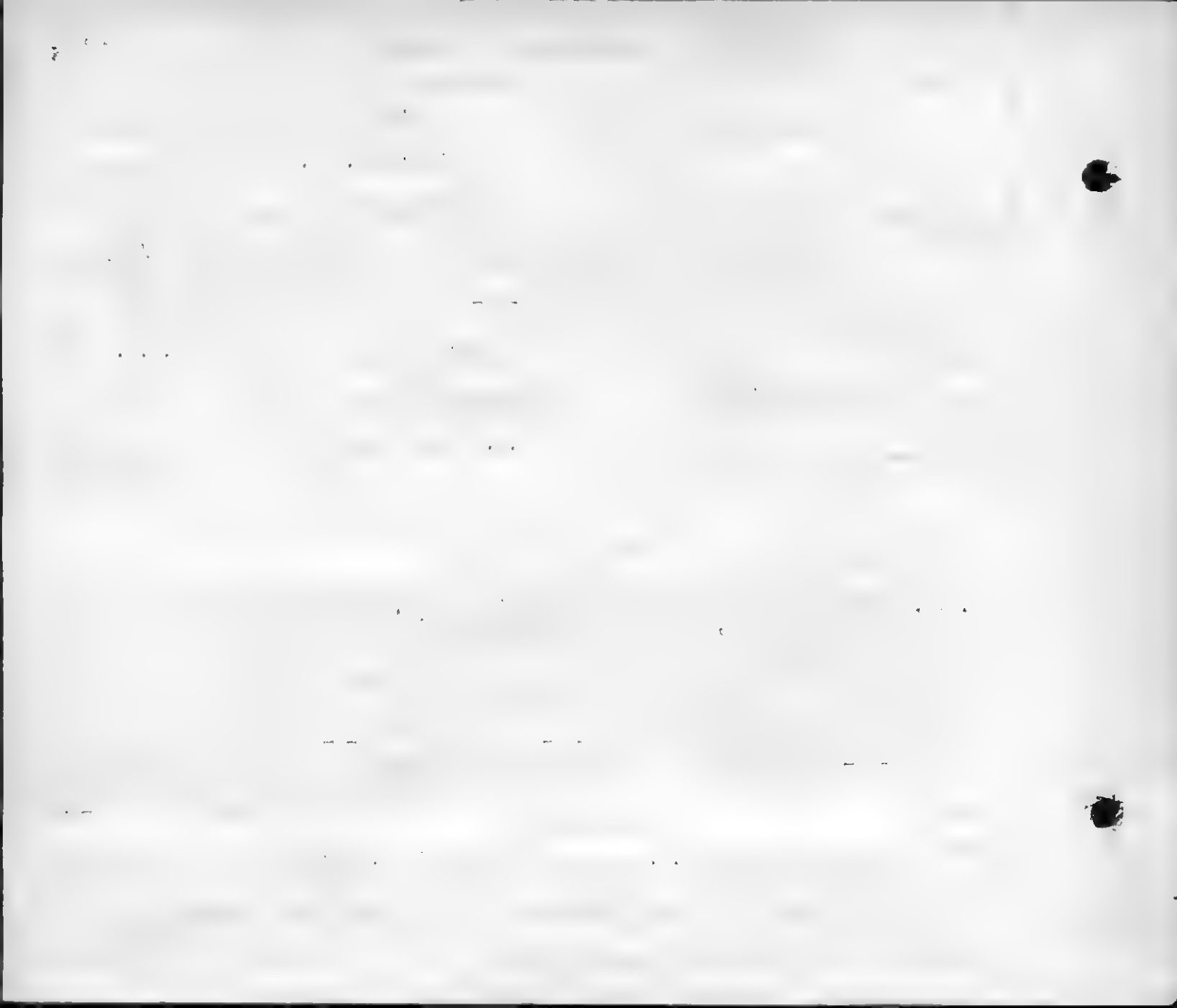
11165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 y 6 m 6 d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Joseph Last Dixon				4. DATE OF DEATH Month 10 Day 4(4) Year 19 58			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-27-90	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 6 Days 10 Hours 4 Min 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shipwork		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Joseph Dixon		14. MOTHER'S MAIDEN NAME Maria Mc Nance		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO none		17. INFORMANT S.S. Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Branchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 47ix DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. of unknown or unspecified cause with psych. reaction Pulmonary tuberculosis, moderately advanced, inactive							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X				20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 10-3-				20g. (County) (State)			
21. I certify that I attended the deceased from 3-27- 19 57 , to 10-3- 19 58 , that I last saw the deceased alive on 10-3- 19 58 , and that death occurred at 1:53A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-4-58			
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/1958		22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) (State) Bald. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Flynn + Fleming, 1422 Light St.				24a. REC'D BY REGISTRAR OCT 1 1958		24b. REGISTRAR'S SIGNATURE C. J. L. & K. H. L.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11177

CERTIFICATE OF DEATH

11166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Garratt	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 5 mos. 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) First Jacob Middle Walter Last DOVE		4. DATE OF DEATH Month October Day 27 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-81
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months — Days —	11. IF UNDER 24 HRS Hours — Min —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY Coal mining	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Isiah Dove		14. MOTHER'S MAIDEN NAME Kathryn Souders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Records of Springfield State Hospital		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) chronic brain syndrome associated with cerebral arterio-sclerosis, with psychotic reaction.		INTERVAL BETWEEN ONSET AND DEATH 3 days more than 15 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from April 29 , 19 58 , to Oct. 27 , 19 58 , that I last saw the deceased alive on Oct. 26 , 19 58 , and that death occurred at 9:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-28-58			
ACTUAL SIGNATURE Walter Knopp		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Walter Knopp, M. D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/30/58	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frederick A. Hargis		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR NOV 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	



11178

CERTIFICATE OF DEATH

11167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY City Bat.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 2 mths 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 2914 Joppa Road			e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Guerke		4. DATE OF DEATH Month 10 Day 5 Year 1958					
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-67	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Joyner			14. MOTHER'S MAIDEN NAME Amanda Flower				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO unkn		17. INFORMANT S.S. Hospital Records			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psych. reaction						INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7-21-1958 to 10-4-1958 , that I last saw the deceased alive on 10-4-1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-5-58							
ACTUAL SIGNATURE Edmund Lusthaus M.D.		DATE SIGNED 10-5-58					
PRINTED NAME (Type) Edmund Lusthaus M.D.		Sykesville, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 10-8-58	22c. NAME OF CEMETERY OR CREMATORY OAKLAND		22d. LOCATION (City, town, or county) (State) Baltimore Md			
23. FUNERAL DIRECTOR'S SIGNATURE Edmund Lusthaus			ADDRESS 5305 Highland		24a. REC'D BY REGISTRAR DATE OCT 7 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11179 CERTIFICATE OF DEATH

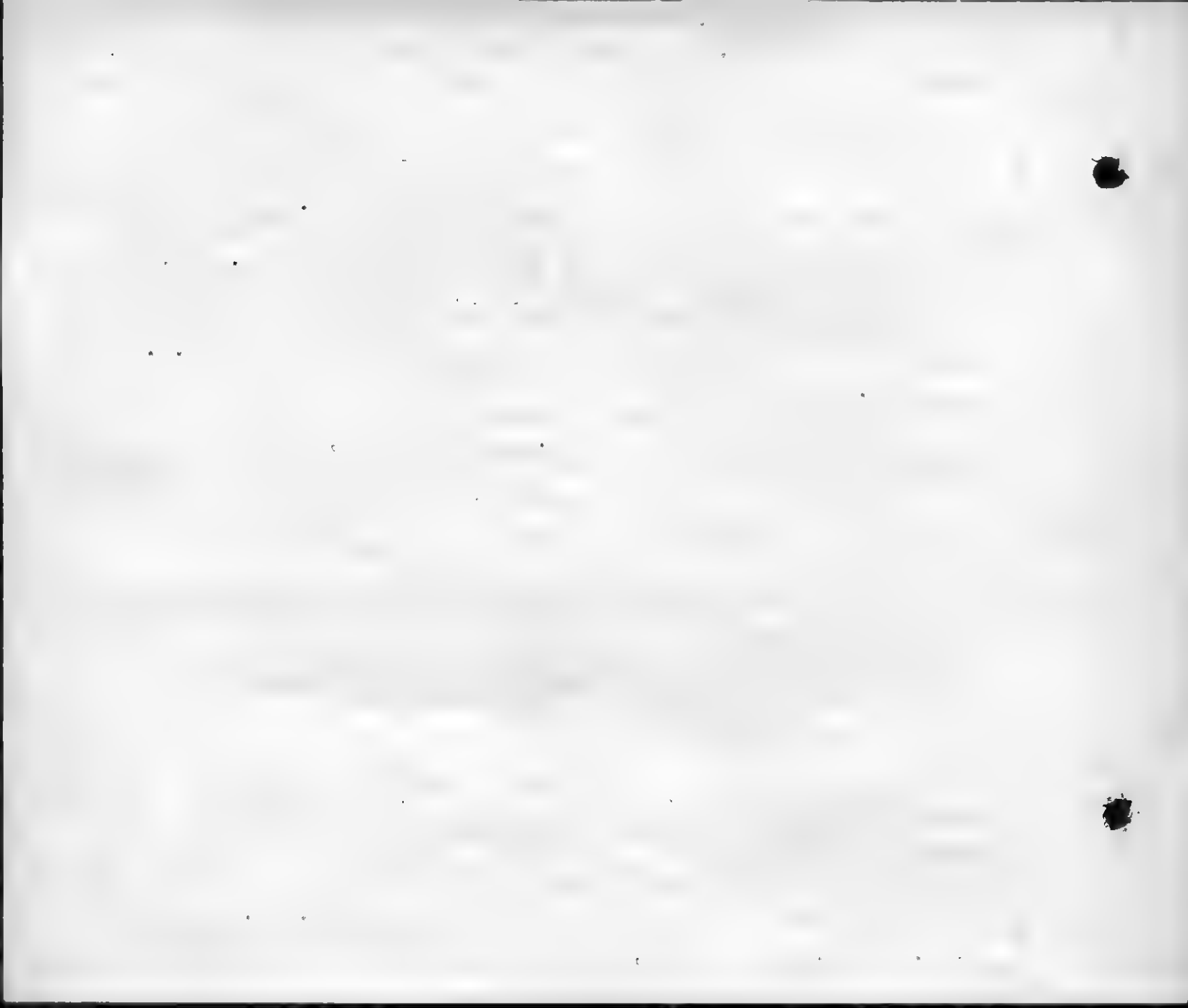
11168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL * Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Klee Mill Rd.</u>		• IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DALE ALLEN HAWKINS</u>				4. DATE OF DEATH Month Day Year <u>OCT. 25, 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-15-1956</u>	
9. AGE (In years last birthday) <u>2 yrs</u>		IF UNDER 1 YEAR: Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min. <u>9</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		13. FATHER'S NAME <u>W. LeRoy Hawkins</u>	
14. MOTHER'S MAIDEN NAME <u>Shirley Murray</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT Address <u>W. LeRoy Hawkins, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter cause of injury in Part I or Part II of item 18) <u>Boy fell out of car & struck wheel</u> <u>apparently ran over his head</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12:15</u> P. M. <u>10/25/58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY or town (County) (State) <u>Sykesville, Carroll Md</u>	
21. I certify that I attended the deceased from <u>10/25</u> , 19 <u>58</u> , to <u>10/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>58</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. LeRoy Hawkins</u> M.D. <u>Westminster Md</u>				DATE SIGNED <u>10/25/58</u>			
PHYSICIAN'S NAME (Type) <u>Acting Deputy Medical Examiner</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-27-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. L. Waltz,</u>				ADDRESS <u>Winfield, Maryland</u>			
24a. REC'D BY REGISTRAR <u>DATE OCT 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kauer</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

11169

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cornell Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cornell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>		d. STREET ADDRESS <u>177 E. Main St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>177 E. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FLORA ELIZABETH HILTABRIDGE</u>		4. DATE OF DEATH <u>OCT. 4 1958</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Cornell Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HELTIBRIDGE</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA DAYHOFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Roy Hiltabridge Westminster, Md.</u>		Address <u>Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>1112 x</u> DUE TO <u>Hypertension & Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, Cardio</u> DUE TO <u>Renal Displacement</u> (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>19-20 yrs</u> <u>10-12 yrs</u> <u>8-10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>60X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1958</u> to <u>Oct 4, 1958</u> , that I last saw the deceased alive on <u>Oct 4, 1958</u> and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Glenn Speicher M.D.</u>		ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>10/6/58</u>	
PHYSICIAN'S NAME (Type) <u>W. Glenn Speicher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 7, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Barnet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myro, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 8 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11180

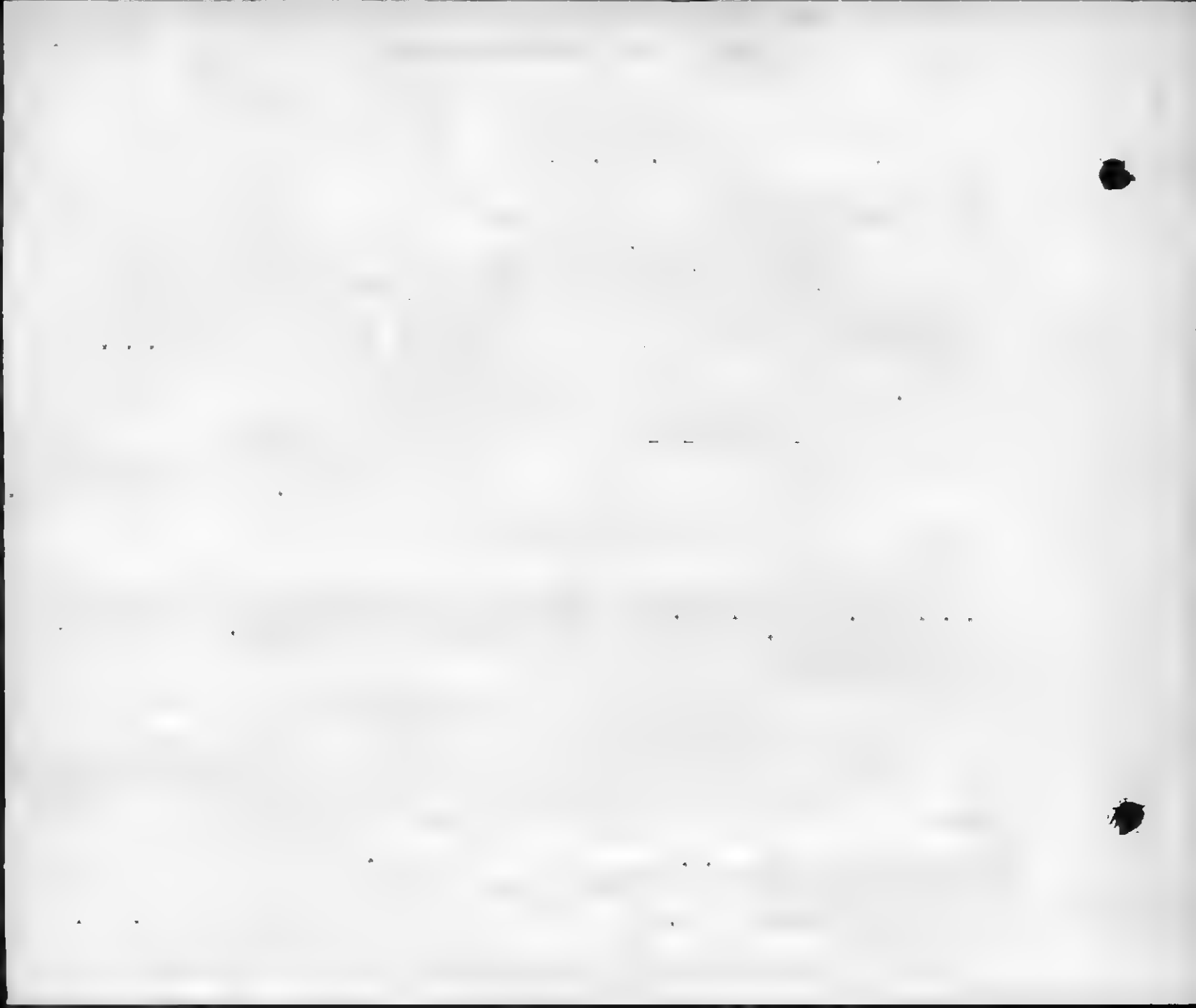
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville,		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Francis Last Hooper		4. DATE OF DEATH Month October Day 7, Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1883
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR: Months 7 Days 19 Hours 58 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph F. Hooper		14. MOTHER'S MAIDEN NAME Lilly Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-10-9627	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE AND NOT GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction. Left direct inguinal hernia with obstruction.			
INTERVAL BETWEEN ONSET AND DEATH More than 10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 18, 19 56 to October 7, 19 58 , that I last saw the deceased alive on October 6, 19 58 , and that death occurred at 8:25A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/7/58 ACTUAL SIGNATURE Walter Knopp M.D. PHYSICIAN'S NAME (Type) Walter Knopp, M.D. Sykesville, Maryland			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/10/58	22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Richard H. Little Littlestown ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 9 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Knapp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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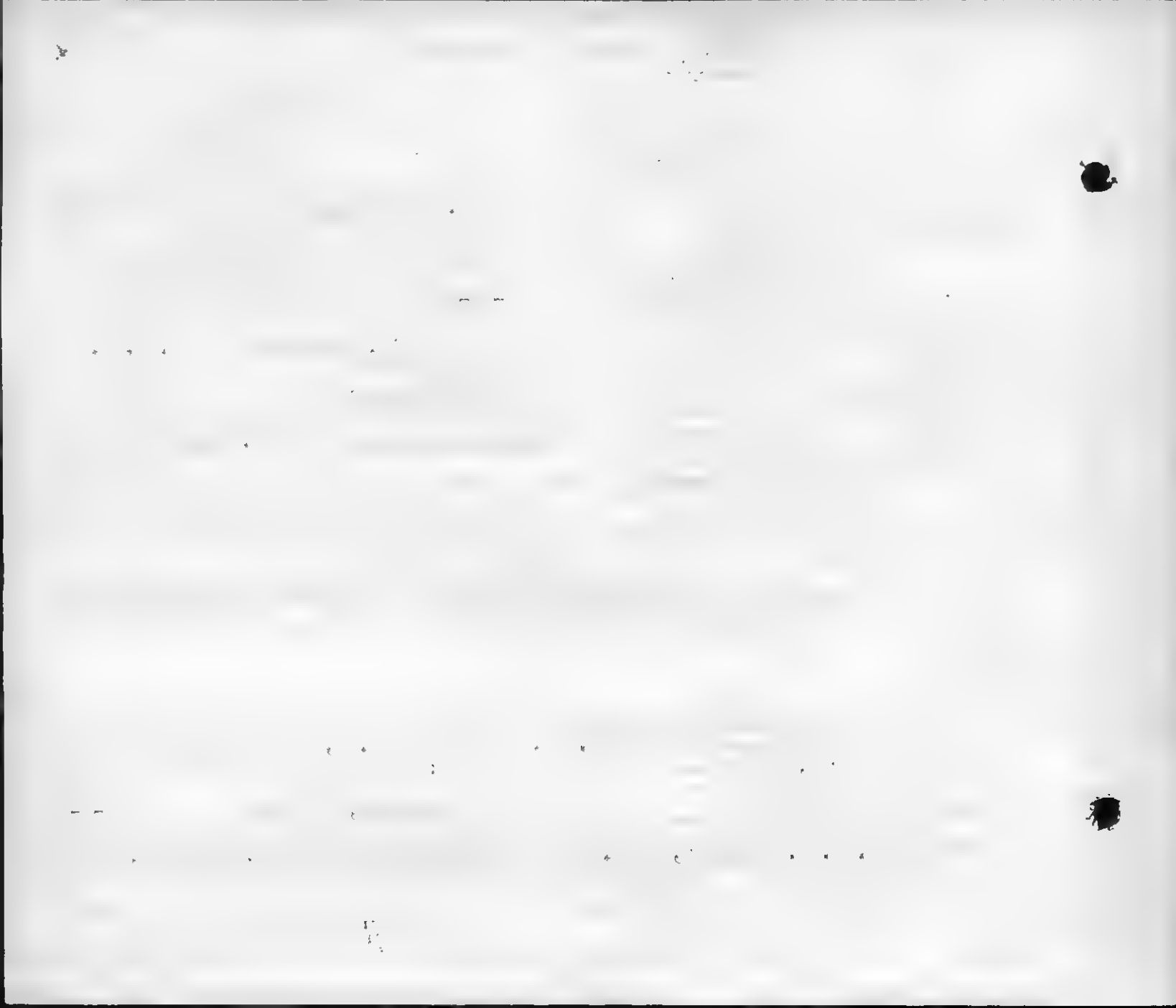
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11181 CERTIFICATE OF DEATH

11171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 371 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. STREET ADDRESS 47 N. West Street			
3. NAME OF DECEASED (Type or print) First Mentheolia Middle Last Jones				4. DATE OF DEATH Month October Day 3 Year 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Separated WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-1925	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Irvin James				14. MOTHER'S MAIDEN NAME Esther Lomax			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mentheolia Jones		Address 47 N. West Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculoma of the brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculous Meningitis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Sept. 27, 1957 , to Oct. 3, 1958 , that I last saw the deceased alive on October 3, 1958 , and that death occurred at 2:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 10-3-58							
ACTUAL SIGNATURE E. M. Maculans				M.D. Henryton, Maryland			
PHYSICIAN'S NAME (Type) Dr. E. M. Maculans, Supt.				Henryton State Hospital, Henryton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-7-58		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III				ADDRESS Annapolis-Md		24a. REC'D BY REGISTRAR DATE OCT 8 '58	
				24b. REGISTRAR'S SIGNATURE Charles E. Hicks			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11182

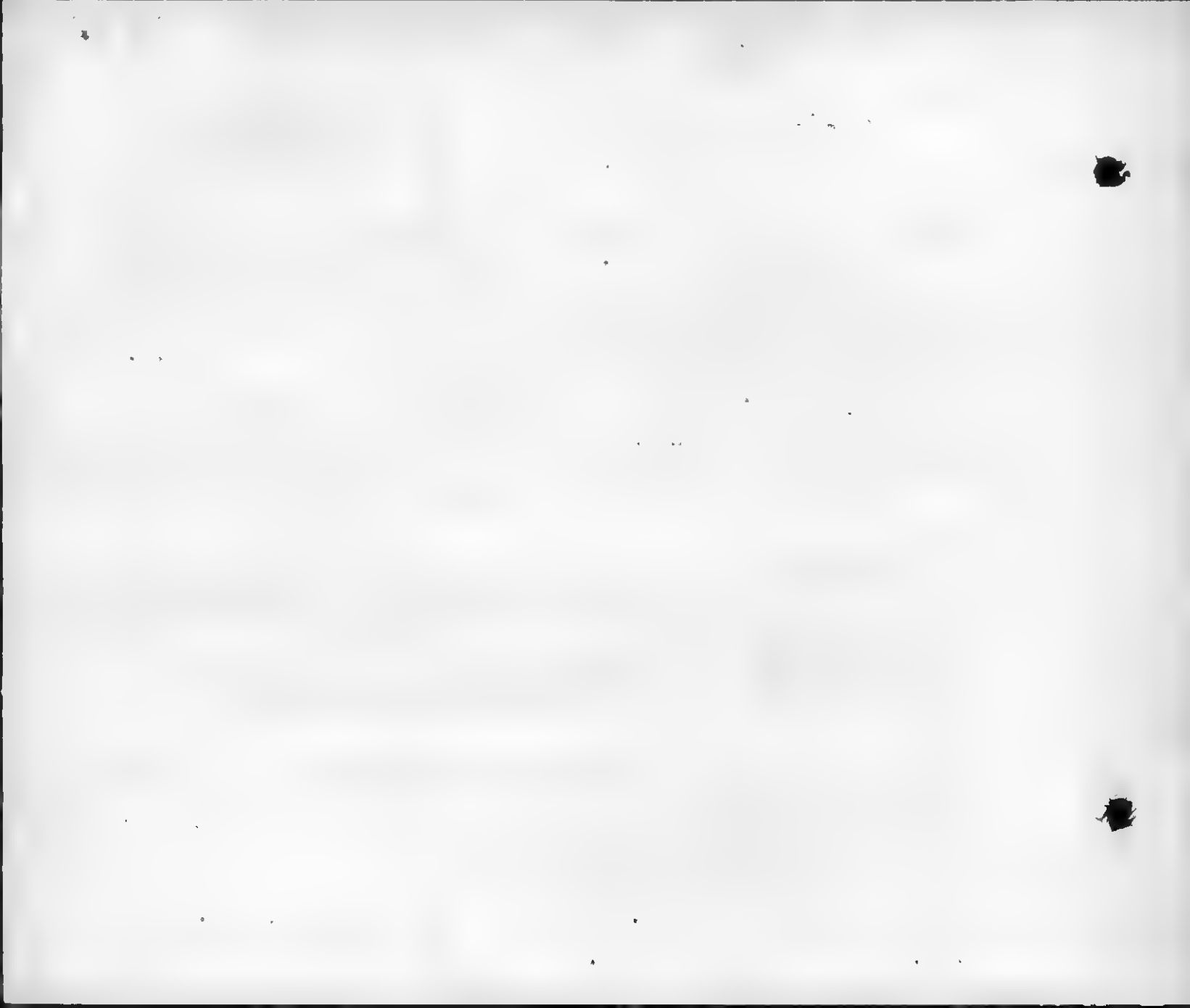
CERTIFICATE OF DEATH

11172

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Finksburg		c. LENGTH OF STAY IN 1b 35 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle W. Last JORDAN		4. DATE OF DEATH Month OCT. Day 15 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1902
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months 0 Days 15 Hours 0 Min. 0	11. IF UNDER 24 HRS Months 0 Days 15 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoe stitcher		10b. KIND OF BUSINESS OR INDUSTRY shoe factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter L. Jordan		14. MOTHER'S MAIDEN NAME Anna Elizabeth Parrish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-9200	
17. INFORMANT Mrs. Hilda Jordan,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, Arteriosclerotic Heart Dis, 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema, Left Lung Atelectasis, DUE TO (c) Chronic Liver, Mild Ascites INTERVAL BETWEEN ONSET AND DEATH AUG 58 to 15 OCT 58			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 1958, to OCT , 1958, that I last saw the deceased alive on 15 Oct , 1958, and that death occurred at 9:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		DATE SIGNED Sept 15 Oct 58	
PHYSICIAN'S NAME (Type) HOWARD E. HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-19-1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant	22d. LOCATION (City, town, or county) (State) Gamber, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. F. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE OCT 20 58		24b. REGISTRAR'S SIGNATURE Waltz	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

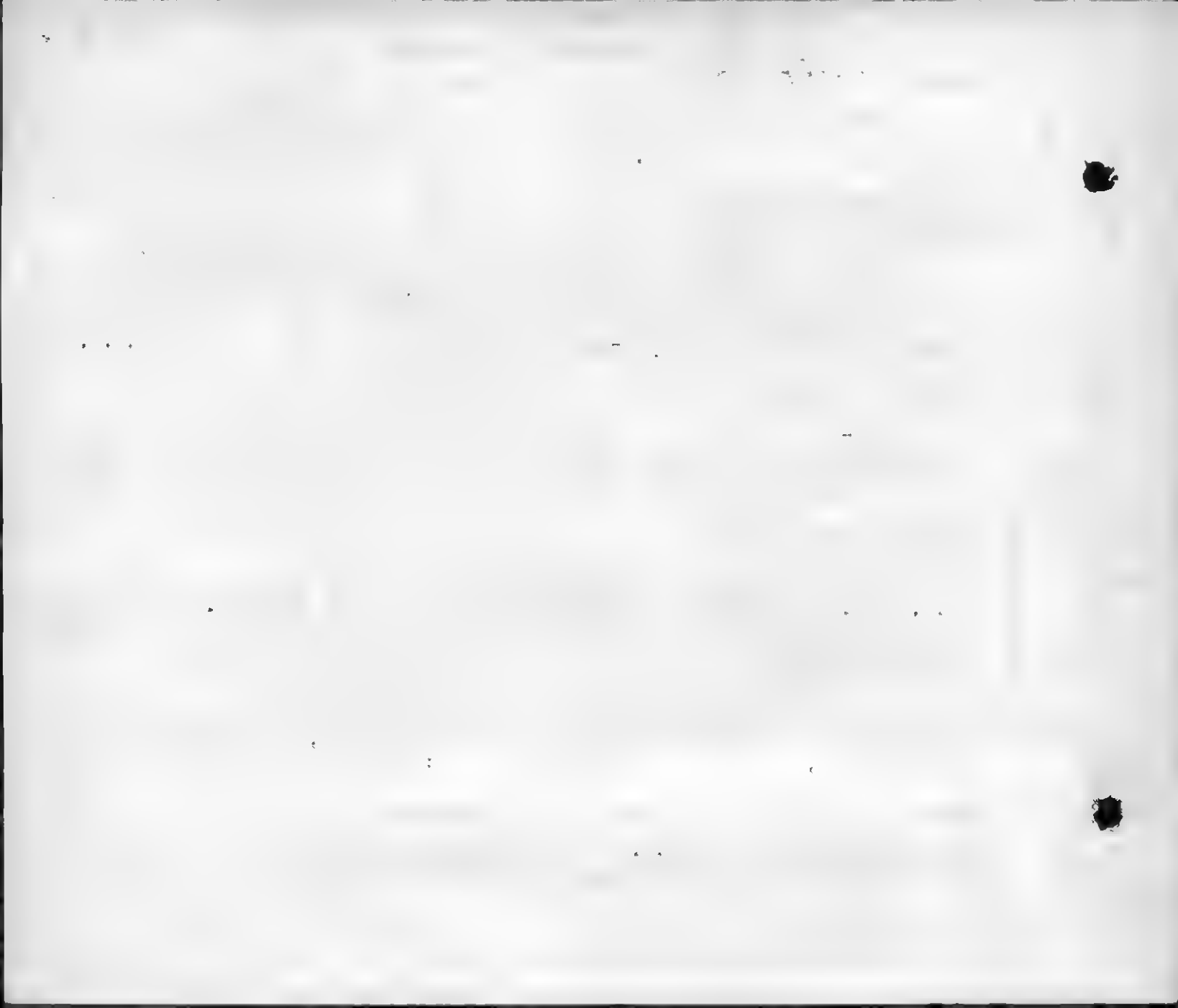


11183 CERTIFICATE OF DEATH

11173

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Little Orleans Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Credy Middle KERLEY Last		4. DATE OF DEATH Month October Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1878
9. AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad worker		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess of lung 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 5, 1958 , to October 8, 1958 , that I last saw the deceased alive on October 8, 1958 , and that death occurred at 8:45 A. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/8/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/11/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) Richie Hwy Ind.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Bowman & Son & Gallins		24a. REC'D BY REGISTRAR DATE OCT 9 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Brown	



11184

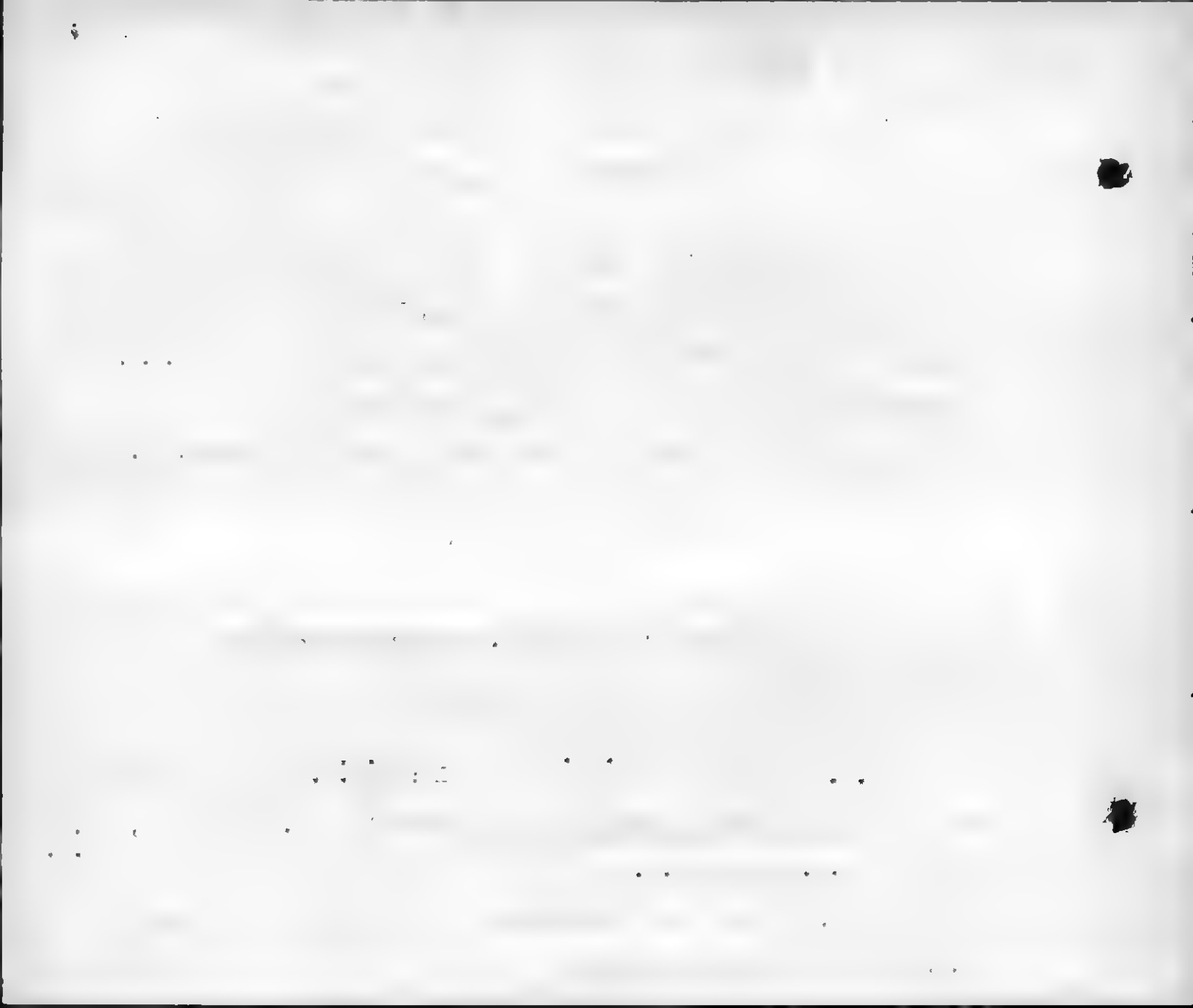
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Detour c. LENGTH OF STAY IN 1b 1 1/2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Detour d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Alfred Kiser		4. DATE OF DEATH Month Day Year October 6, 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1868
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Kiser		14. MOTHER'S MAIDEN NAME Alice Rowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Carroll Dougherty		Address Detour, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 10 years 15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arteriosclerotic Nephritis. Cerebral Hemorrhage			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5.21.40 , 19___, to 10.6.58 , 19___, that I last saw the deceased alive on 10.5.58 , 19___, and that death occurred at 10:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Frederick St. Taneytown, Md. DATE SIGNED 10.7.58			
ACTUAL SIGNATURE R. S. McVaugh		M.D. 49 Frederick St. Taneytown, Md.	
PHYSICIAN'S NAME (Type) R. S. McVaugh M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1958	
22c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery		22d. LOCATION (City, town, or county) (State) Keysville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son, Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE OCT 9 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11185

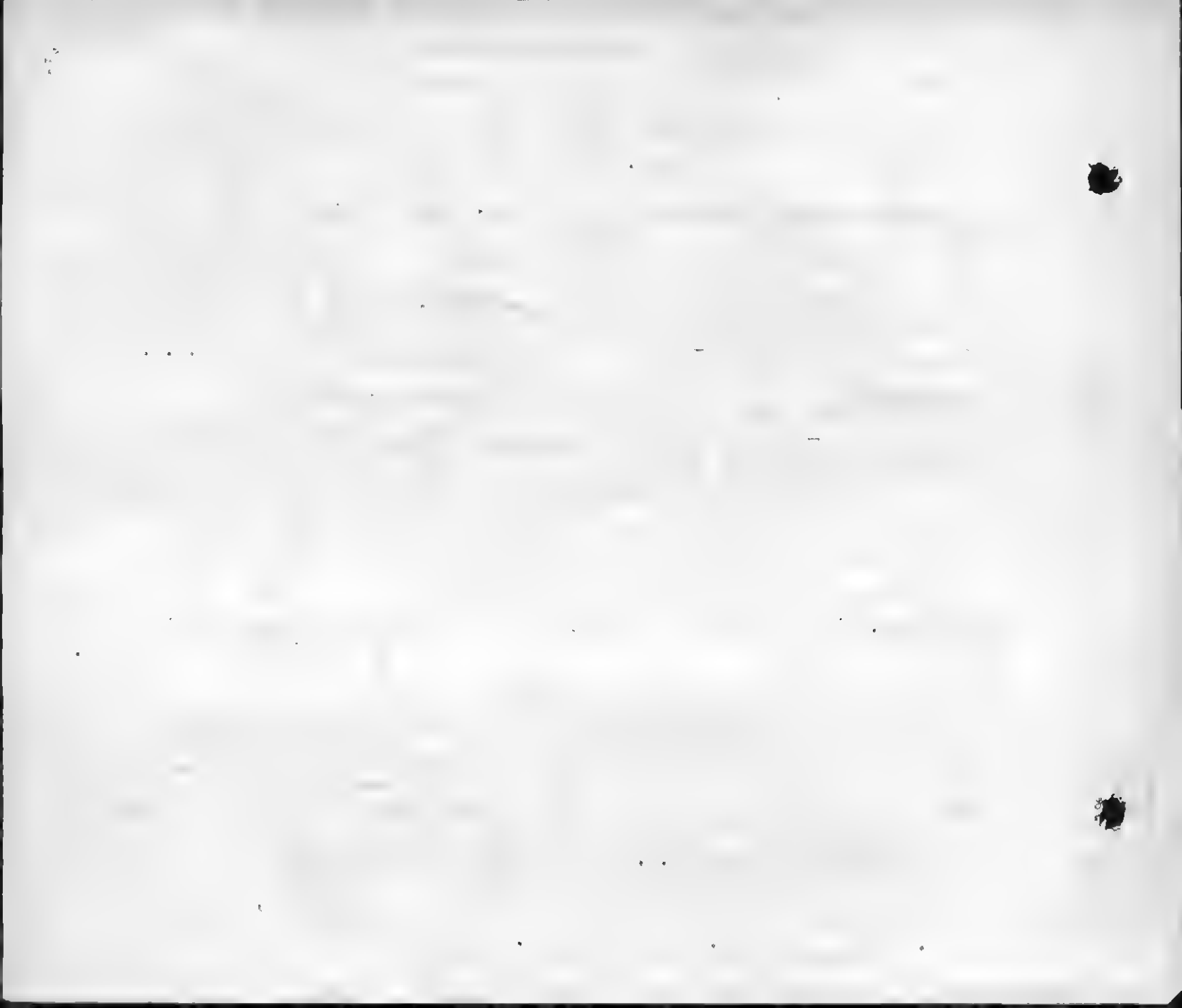
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 17 days Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 115 S. Conklin Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle John Last Kuhn		4. DATE OF DEATH Month October Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1912
9. AGE (In years last b'day) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 17 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Kuhn		14. MOTHER'S MAIDEN NAME Frances Schroeder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO -	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4712 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -		INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with convulsive disorder, mental deficiency without psychosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) due to epidemic encephalitis.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30 , 19 58 to October 17 , 19 58 , that I last saw the deceased alive on October 17 , 19 58 , and that death occurred at 9:00 a. m. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Agustin del Campo M.D.		Springfield State Hospital 10/17/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 20, 1958	22c. NAME OF CEMETERY OR CREMATORY Schwartz Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24a. REC'D BY REGISTRAR 3000 E. Baltimore St.	
24b. REGISTRAR'S SIGNATURE John S. Frank		DATE OCT 2 58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11186

CERTIFICATE OF DEATH

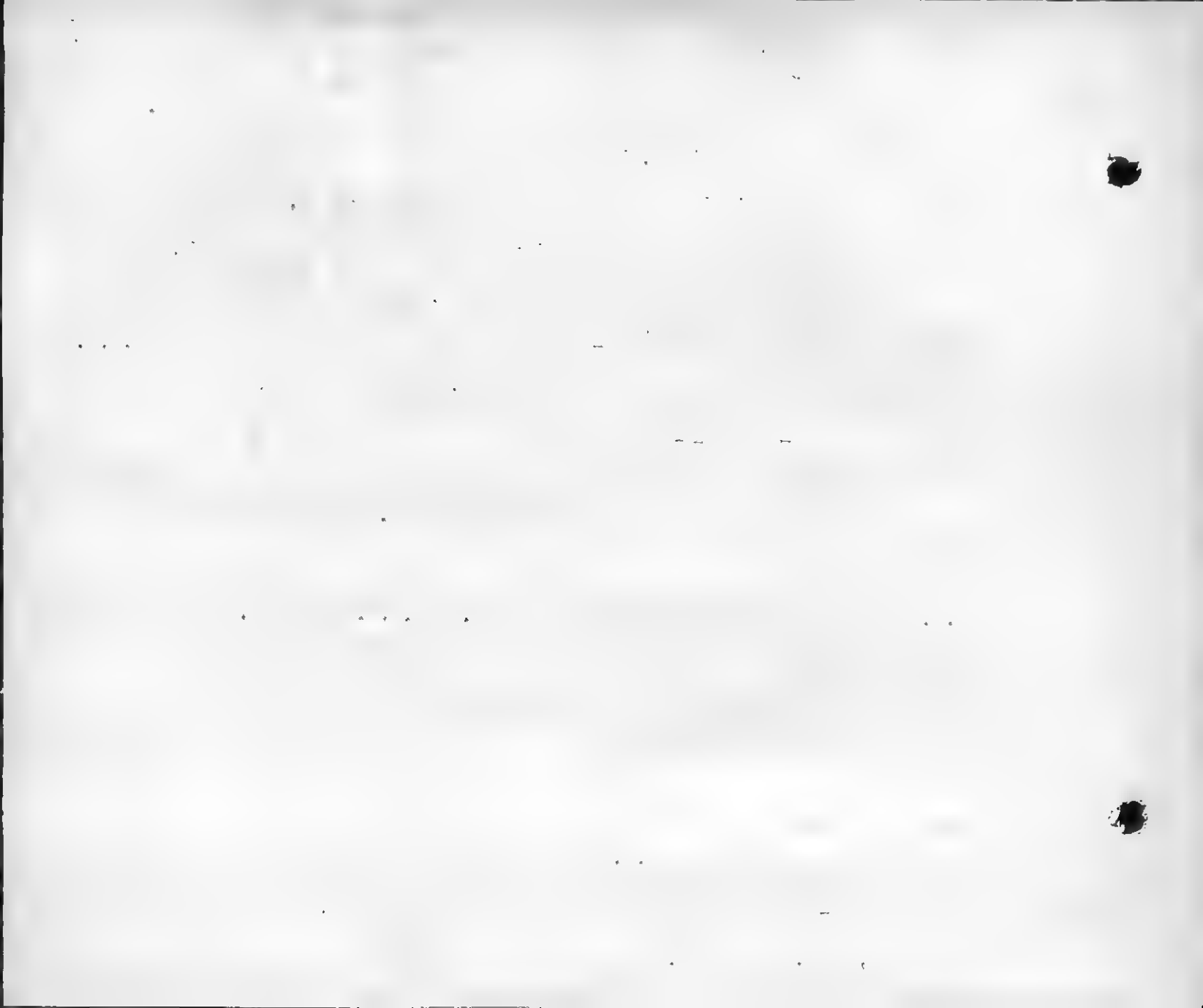
Reg. Dist. No. 11176

1. PLACE OF DEATH a COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE Maryland b COUNTY Balto. City			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c LENGTH OF STAY IN 1b 4 mos. 17 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d STREET ADDRESS 1748 Abbottson St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last (Frank) Francis Joseph Leikam				4. DATE OF DEATH Month Day Year October 27, 19 58			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 17, 1889		9 AGE (In years last birthday) yrs 69	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Truck Helper		10b KIND OF BUSINESS OR INDUSTRY Gunther's Brewery -		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Joseph Leikam				14 MOTHER'S MAIDEN NAME Unknown Mary (unknown)			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 220-14-3610A		17. INFORMANT Address Springfield Hospital Records			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction of myocardium from coronary thrombosis due to arteritis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to arteriosclerotic heart disease. C.N.S. Syphilis.							INTERVAL BETWEEN ONSET AND DEATH Weeks
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 19 58 to October 27, 19 58 that I last saw the deceased alive on October 27, 19 58 , and that death occurred at 9:27 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/27/58 ACTUAL SIGNATURE Agustin del Campo PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland							
22a BURIAL CREMATION, REINTERMENT (Specify) BURIAL		22b DATE THEREOF 10-30-58		22c NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d LOCATION (City, town, or county) (State) 7401 Berman Hill Road	
23 FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a REC'D BY REGISTRAR ACT 2 9 '58		24b REGISTRAR'S SIGNATURE C. S. Kraus	

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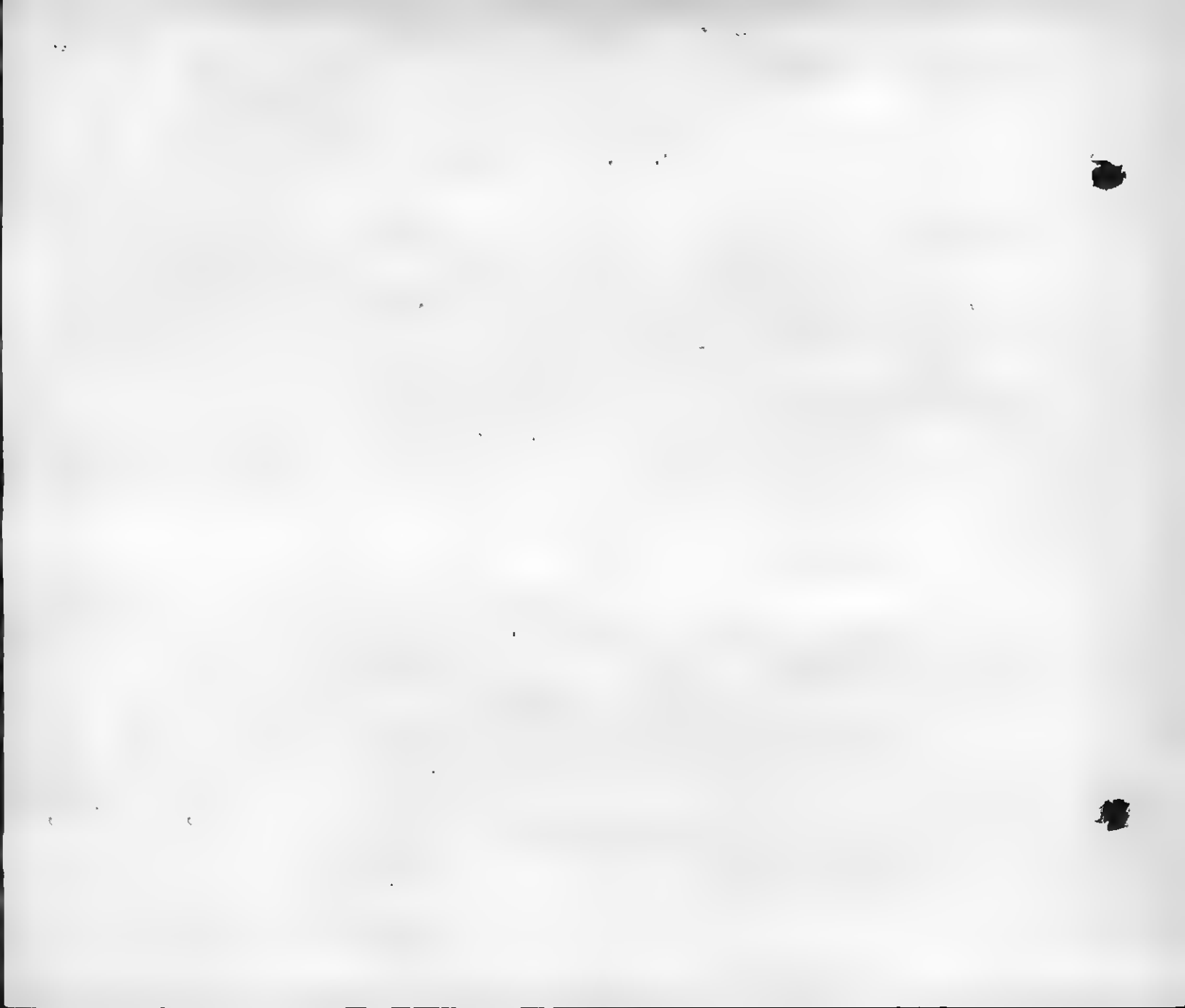


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 9 Filed 10-21-58 et
 11187 CERTIFICATE OF DEATH

11177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 22yr. 1mo. 2days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Luigi Middle Lieto Last Lieto				4. DATE OF DEATH Month October Day 7 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 19, 1896	
				9. AGE (In years last birthday) 64 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Truck Co.		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. U. S.		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatitis 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7 , 19 55 , to October 7 , 19 58 , that I last saw the deceased alive on October 7 , 19 58 , and that death occurred at 4:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, DATE SIGNED Agustin del Campo							
ACTUAL SIGNATURE Agustin del Campo				M.D. Springfield State Hospital, Sykesville,			
PHYSICIAN'S NAME (Type) Agustin del Campo				Maryland, 10/7/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORY New Catholic		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight, Jr. ADDRESS Sykesville, Md.				24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	



11188

CERTIFICATE OF DEATH

Reg. Dist. No. 11178

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster		c. LENGTH OF STAY IN TB 6mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural--Westminster	
		f. STREET ADDRESS 1 R.D. # 6	
3. NAME OF DECEASED (Type or print) First MARIE Middle VIRGINIA Last MARTIN		4. DATE OF DEATH Month Oct Day 6 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-1893
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.	11. IF UNDER 24 HRS Months 6 Days 15 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elgouis Doster		14. MOTHER'S MAIDEN NAME Annie r. Gillard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Arthur C. Shipley, Sr.		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) U.S.C.V. Disease DUE TO (c) 21 years		INTERVAL BETWEEN ONSET AND DEATH 21 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1958 , to Oct 6 1958 , that I last saw the deceased alive on Oct 5 1958 , and that death occurred at 4:47 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James J. Marsh		ADDRESS (Street, city or town, state) 105 E MAIN St. WESTMINSTER MD	
DATE SIGNED 10/6/58			
PHYSICIAN'S NAME (Type) JAMES T. MARSH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-8-1958	22c. NAME OF CEMETERY OR CREMATORY Harmony Grove	22d. LOCATION (City, town, or county) (State) Carroll Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE OCT 8 58		24b. REGISTRAR'S SIGNATURE Robert S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11189

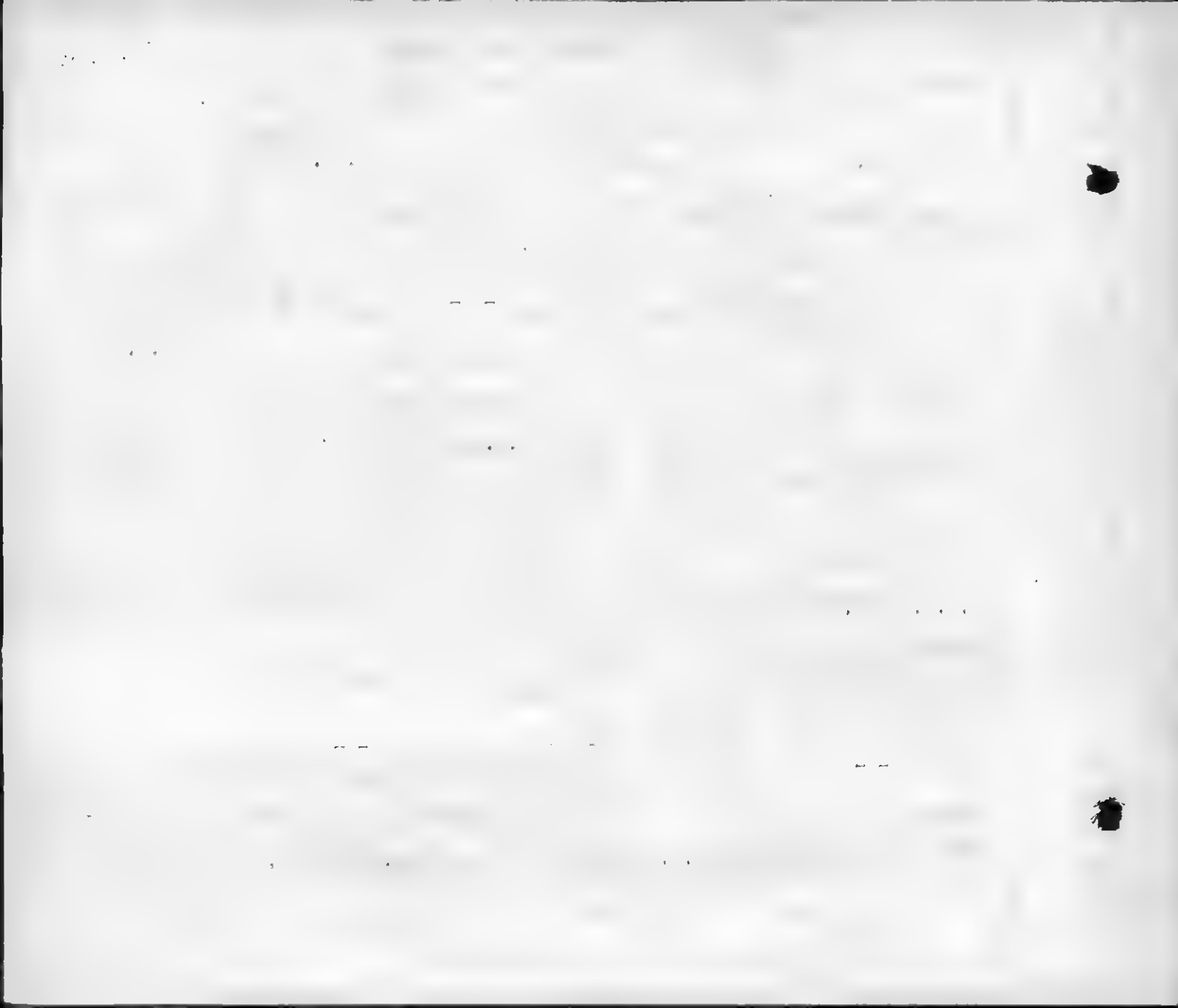
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville,				c. LENGTH OF STAY IN 1b 1m 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle L. Last Mishenko				4. DATE OF DEATH Month 10 Day 4 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH For 9-12-07	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Leibold				14. MOTHER'S MAIDEN NAME Alice Raybold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO unkn		17. INFORMANT S.S. Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriolar nephrosclerosis DUE TO 446x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction				INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-22- 1958, to 10-4- 1958, that I last saw the deceased alive on 10-4- 1958, and that death occurred at 8:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 10-4-58							
ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital 10-4-58							
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-7-58		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard Luck				ADDRESS 5305 Hayport		24a. REC'D BY REGISTRAR Arthur S. Thrash	
				DATE OCT 7 1958			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11190 CERTIFICATE OF DEATH

11180

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Taneytown		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Taneytown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS 15 York Street		(If rural give location)	
3. NAME OF (First) (Middle) (Last) William C. N. Myers				4. DATE OF DEATH (Month) (Day) (Year) October 26, 19 58			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 30, 1879	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerome Myers				14. MOTHER'S MAIDEN NAME Sarah Jane Koontz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Lloyd Myers, Taneytown, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Myocarditis Chronic						6 mo	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis						2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Cancer Jaw (Tissue)						1 year	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 17, 19 52</u> , to <u>10/26, 19 58</u> , that I last saw the deceased alive on <u>Oct 17, 19 58</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE E. Ambler Thompson M.D.				ADDRESS (Street, city, town, state) Taneytown Md		DATE SIGNED 10/27/58	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF October 29, 1958		NAME OF CEMETERY OR CREMATORY Reformed Cemetery		LOCATION (City, town, or county) (State) Taneytown, Maryland	
24. REC'D BY REGISTRAR OCT 28 '58		REGISTRAR'S SIGNATURE E. Ambler Thompson		25. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son		ADDRESS Taneytown, Maryland	

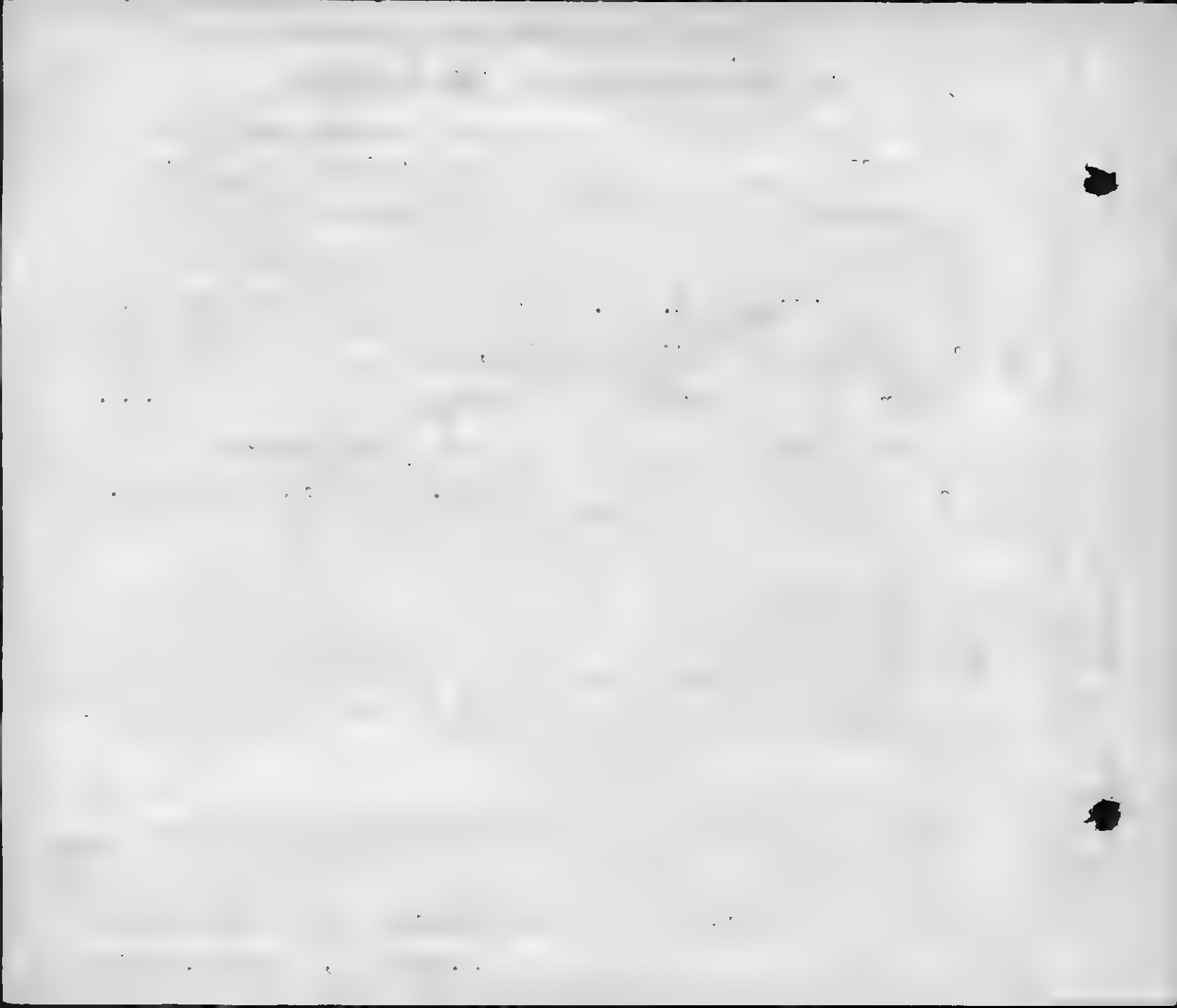
INSTRUCTIONS

1
7

PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191

CERTIFICATE OF DEATH

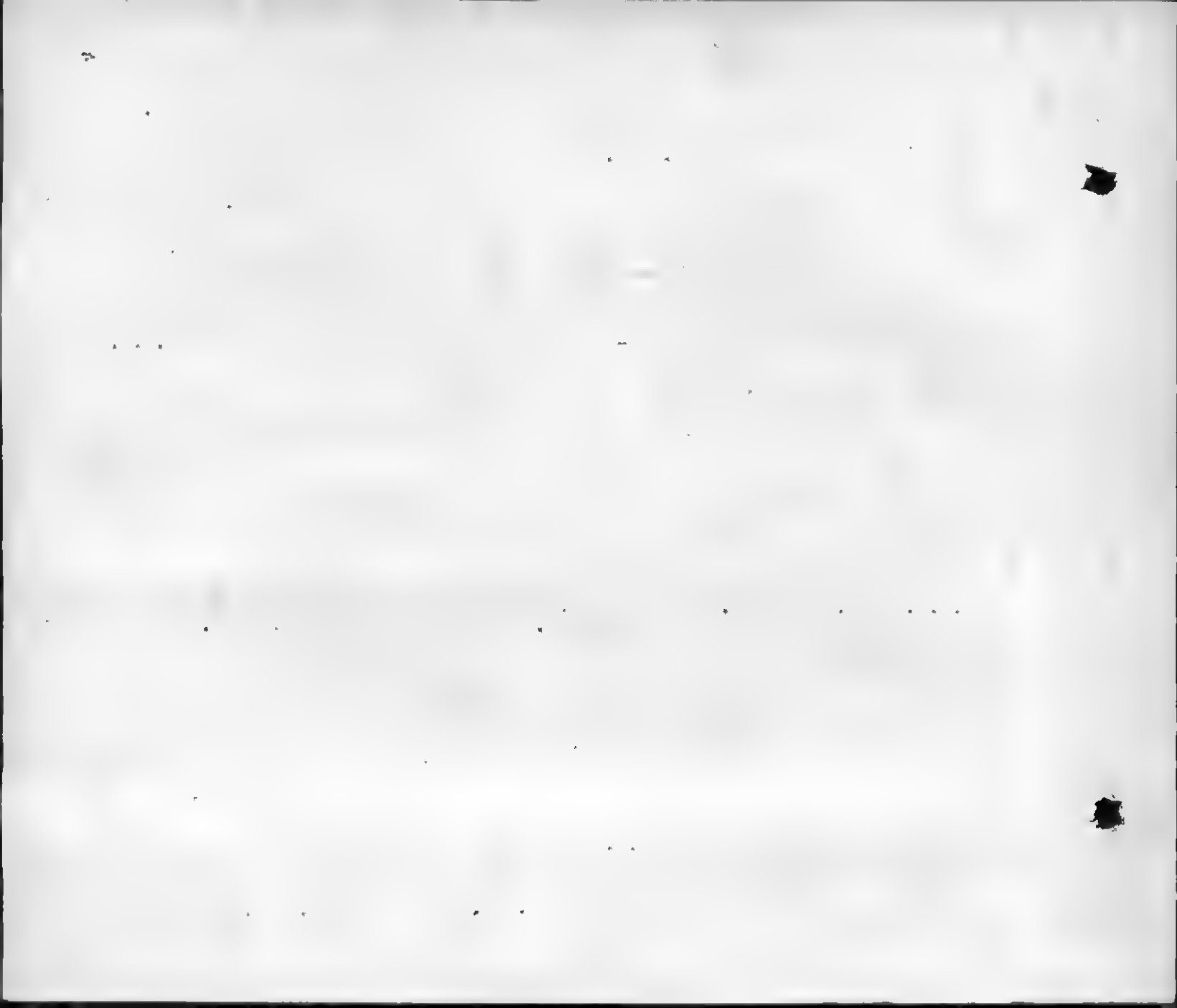
11181

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore 34	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d STREET ADDRESS 9301 Old Harford Rd.	
3. NAME OF DECEASED (Type or print) First Amy Middle Amanda Last Gardiner Old		4. DATE OF DEATH Month October Day 8 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARITAL STATUS WIDOWED	8. DATE OF BIRTH November 14, 1876
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown George I. Gardiner		14 MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) -			INTERVAL BETWEEN ONSET AND DEATH Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. or metabolism, growth or nutrition, with senile brain disease with psychotic reaction, Fracture, neck of femur, right,			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 4914		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 18, 1958 , to October 8, 1958 , that I last saw the deceased alive on October 8, 1958 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		DATE SIGNED 10/9/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/11/58	22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23 FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.		24. REC'D BY REGISTRAR Oct 14 '58	
24b REGISTRAR'S SIGNATURE Arthur S. Krawe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

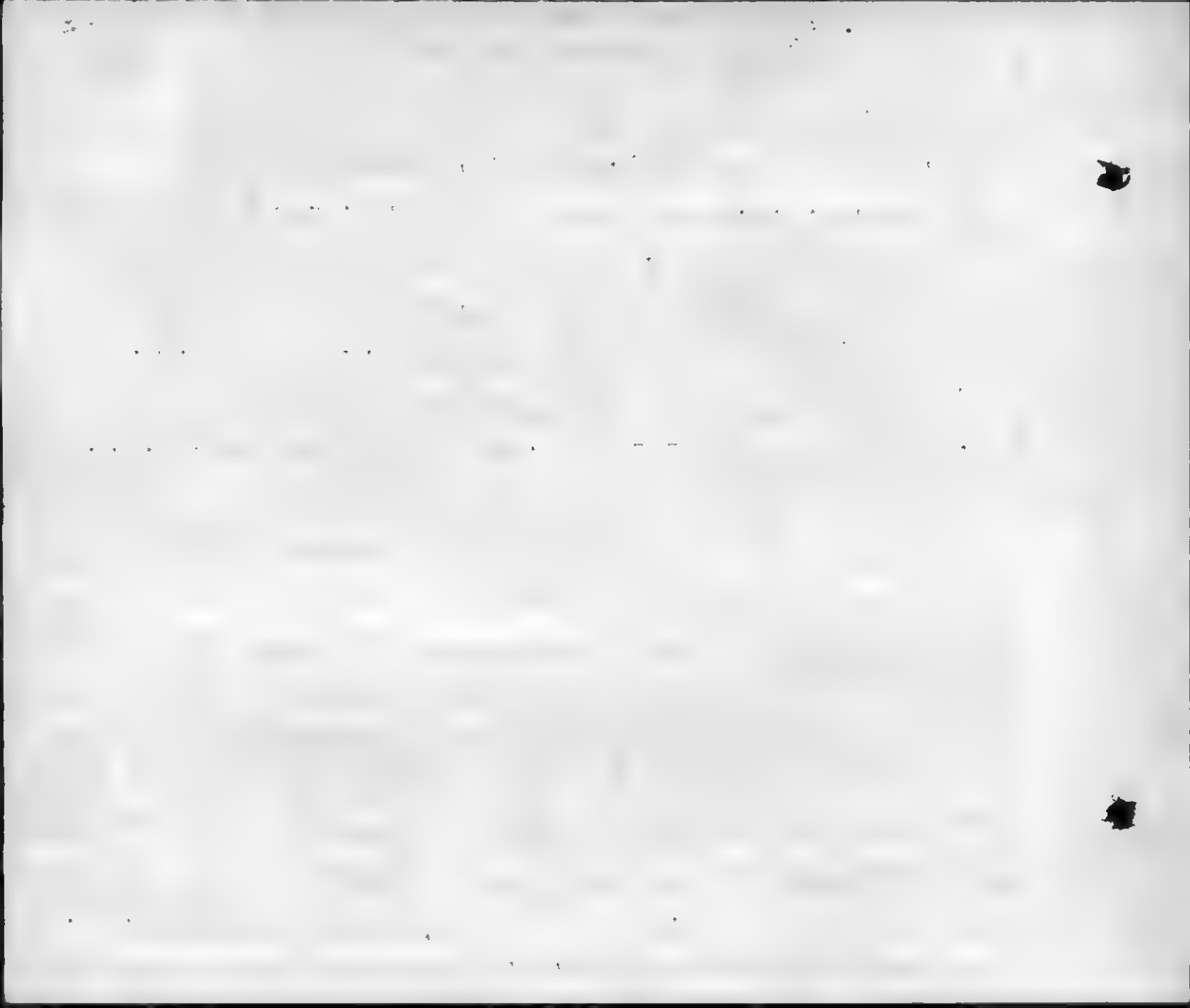
11192

CERTIFICATE OF DEATH

Reg. Dist. No.

11182

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster				c. LENGTH OF STAY IN 1b 15 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 1				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster, Md. R. D. 1			
3. NAME OF DECEASED (Type or print) First Andy Middle S. Last Osborne				4. DATE OF DEATH Month October Day 26 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1881		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Parker, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Osborne				14. MOTHER'S MAIDEN NAME Martha Jane Breedlove			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO. 213-18-9199		17. INFORMANT Mrs. Bertha Osborne Address Westminster, Md. R.D.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis & DUE TO (c) Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 5026 hrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan 1955 to Oct 26, 1958 , that I last saw the deceased alive on Oct 14, 1958 , and that death occurred at 12:01 A. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. L. H. Speicher				ADDRESS (Street, city or town, state) Westminster Md			
PHYSICIAN'S NAME (Type) W. L. H. Speicher				DATE SIGNED 10/27/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/58		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE OCT 28 1958	
				24b. REGISTRAR'S SIGNATURE Arthur B. Kline			



11193

CERTIFICATE OF DEATH

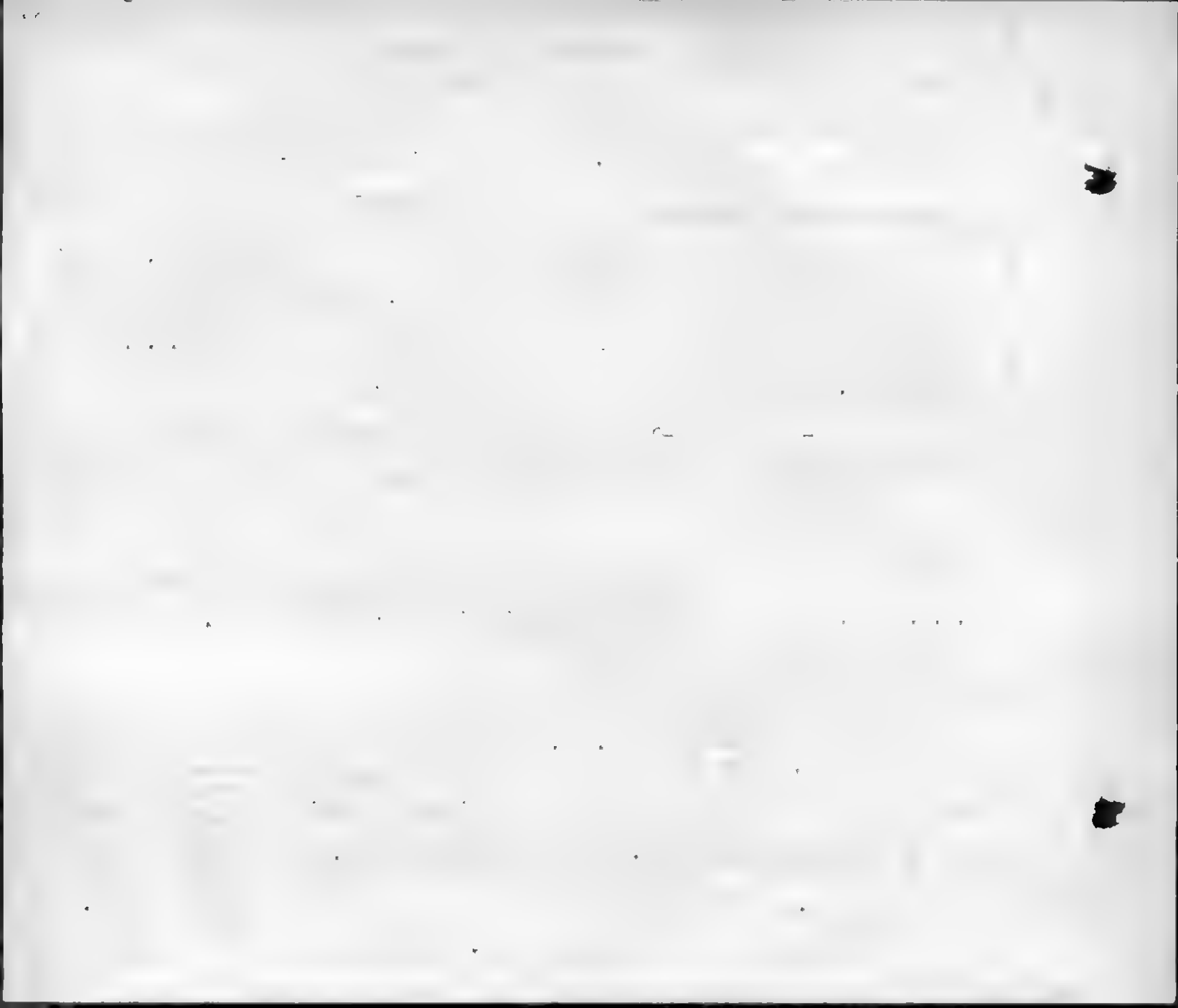
11183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 10 mos. 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Route #1	
3. NAME OF DECEASED (Type or print) First Middle Last Nettie Florence Duvall PURDUM		4. DATE OF DEATH Month Day Year October 6, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1893
9. AGE (in years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY OWN Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachariah T. Duvall		14. MOTHER'S MAIDEN NAME Marian Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 577-03-6502-D	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 22, 1957 , to October 6, 1958 , that I last saw the deceased alive on October 5, 1958 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 10/6/58			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		DATE SIGNED 10/6/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8 58	22c. NAME OF CEMETERY OR CREMATORY Wesley Grove	22d. LOCATION (City, town, or county) (State) Woodfield Md.
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR DATE OCT 9 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11184

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

11194

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on. Residence before adm'ss on) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 3yrs. 10mos. 20days		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital	
e. STREET ADDRESS 1538 Stonewood Rd.		f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) May Belle Lantz Reeve		4. DATE OF DEATH Month October Day 29 Year 19 58	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1872	
9. AGE (In years last b. day) 86 yrs		10. IF UNDER 1 YEAR Months 8 Days 29 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Lantz		14. MOTHER'S MAIDEN NAME Elizabeth Lantz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 491X	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 491X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition with senile brain disease with psychotic reaction. Fracture, comminuted, right femur. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 9047		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Pushed to floor by another patient.	
20c. TIME OF INJURY Month, Day, Year 4:45 p.m. 10/15/1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		DATE SIGNED 10/30/58	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried at St. Agnes		22b. DATE THEREOF 11-2-58	
22c. NAME OF CEMETERY OR CREMATORY Hampton		22d. LOCATION (City, town, or county) (State) Hampton, Prince Georges, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Haight		24a. REC'D BY REGISTRAR NOV 3 '58	
24b. REGISTRAR'S SIGNATURE C. L. S. Thoma			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in permanent within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11195

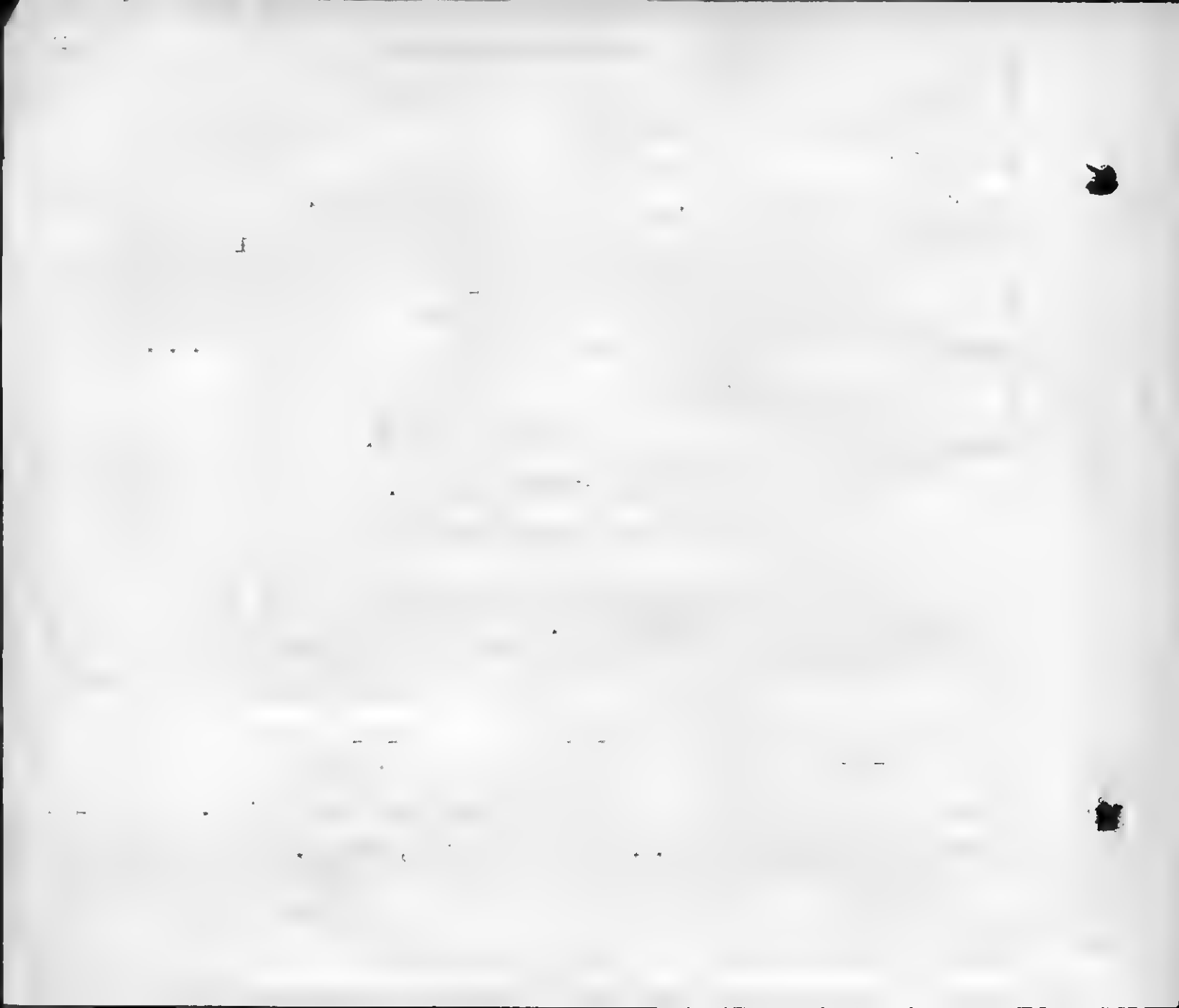
CERTIFICATE OF DEATH

11185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b one year 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 225 Winter Street.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alvia Middle Last Reichard		4. DATE OF DEATH Oct. 19 Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-80
		9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ELEC. PLANT EMPLOYEE		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Theodore Reichard		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown N/A		16. SOCIAL SECURITY NO NONE	
		17. INFORMANT Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain syndrome associated with arteriosclerosis and circulatory disturbances with psychotic reactions.		INTERVAL BETWEEN ONSET AND DEATH years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-18-57 , 19 57 , to 11-25- , 19 58 , that I lost saw the deceased alive on 11-25- , 19 58 , and that death occurred at 9:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 11-26-58			
ACTUAL SIGNATURE Agustin del Campo		M.D. Springfield State Hospital.	
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/28/58	Rose Hill Cem.	Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR OCT 28 '58	
		24b. REGISTRAR'S SIGNATURE Charles E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11196

CERTIFICATE OF DEATH

11186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (22), Md.	
c. LENGTH OF STAY IN lb 1 m 14 days		d. STREET ADDRESS 6743 Woodley Rd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonard Middle Smith Last Richardson		4. DATE OF DEATH Month 10 Day 19 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 - 21 - 71
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mill worker		10b. KIND OF BUSINESS OR INDUSTRY STEEL MFG'G	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Richardson		14. MOTHER'S MAIDEN NAME Helen Everson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4 d.d. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9 - 5 - 1958 , to 10 - 19 - 1958 , that I last saw the deceased alive on 10 - 18 - 1958 , and that death occurred at 1:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund Lusthaus M.D. Springfield State Hospital 10-19-58			
ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital 10-19-58			
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	10/23/58	UNION	STUBENVILLE OHIO
23. FUNERAL DIRECTOR'S SIGNATURE Walter R. ...		ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 21 1958
			24b. REGISTRAR'S SIGNATURE Arthur S. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

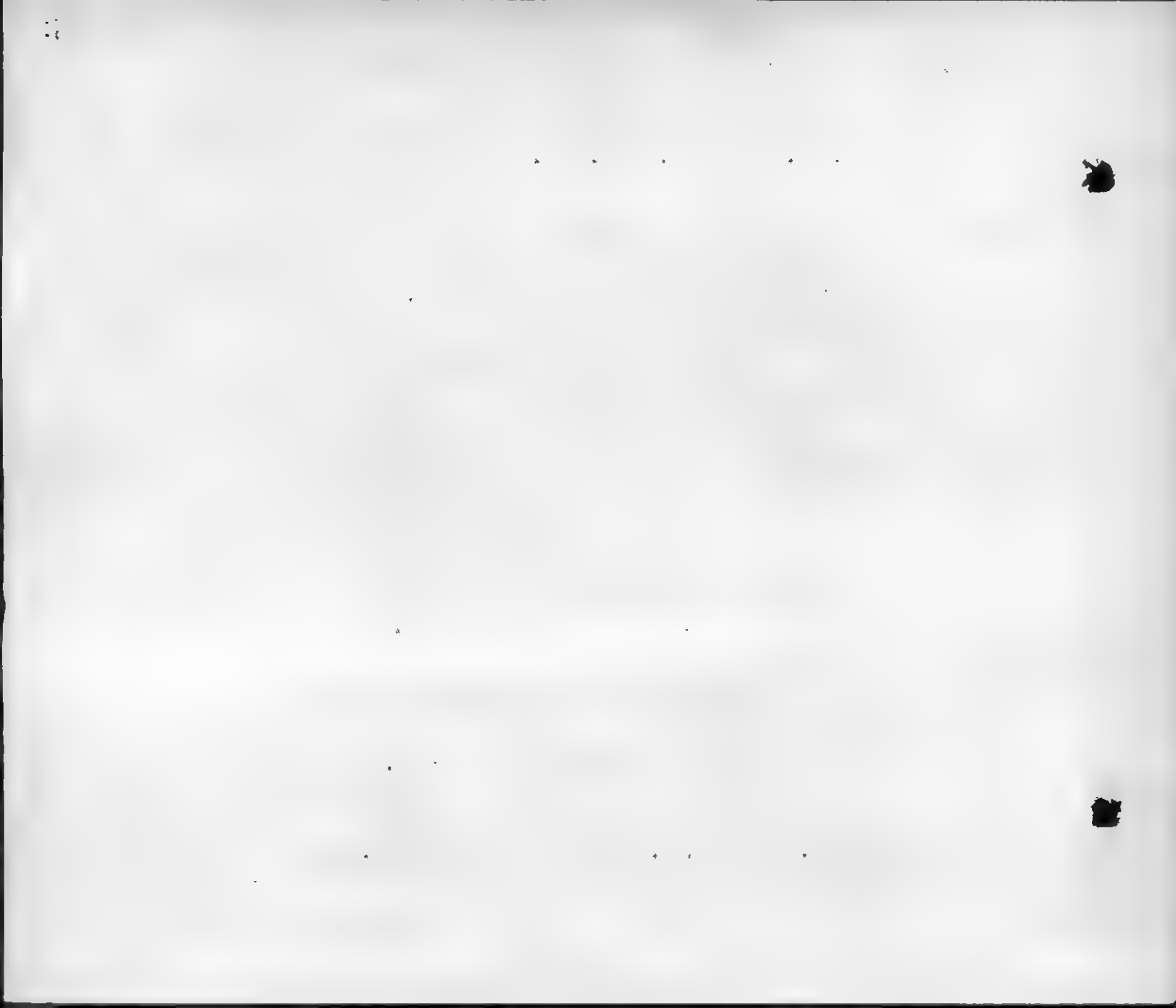
11187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>4700 Warford Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Margaret</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 6, 1873</u>	
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Unknown U.S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Springfield State Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO <u>aspiration of food</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u>chronic Rheumatic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>days</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u> (b) <u> </u> (c) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>October 7, 1958</u> , that I last saw the deceased alive on <u>October 7, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rita S. Glahn</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>10/7/58</u>	
PHYSICIAN'S NAME (Type) <u>Rita S. Glahn, M. D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>Oct 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. Spemann</u>				ADDRESS <u>6067 Harf. Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clinton S. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

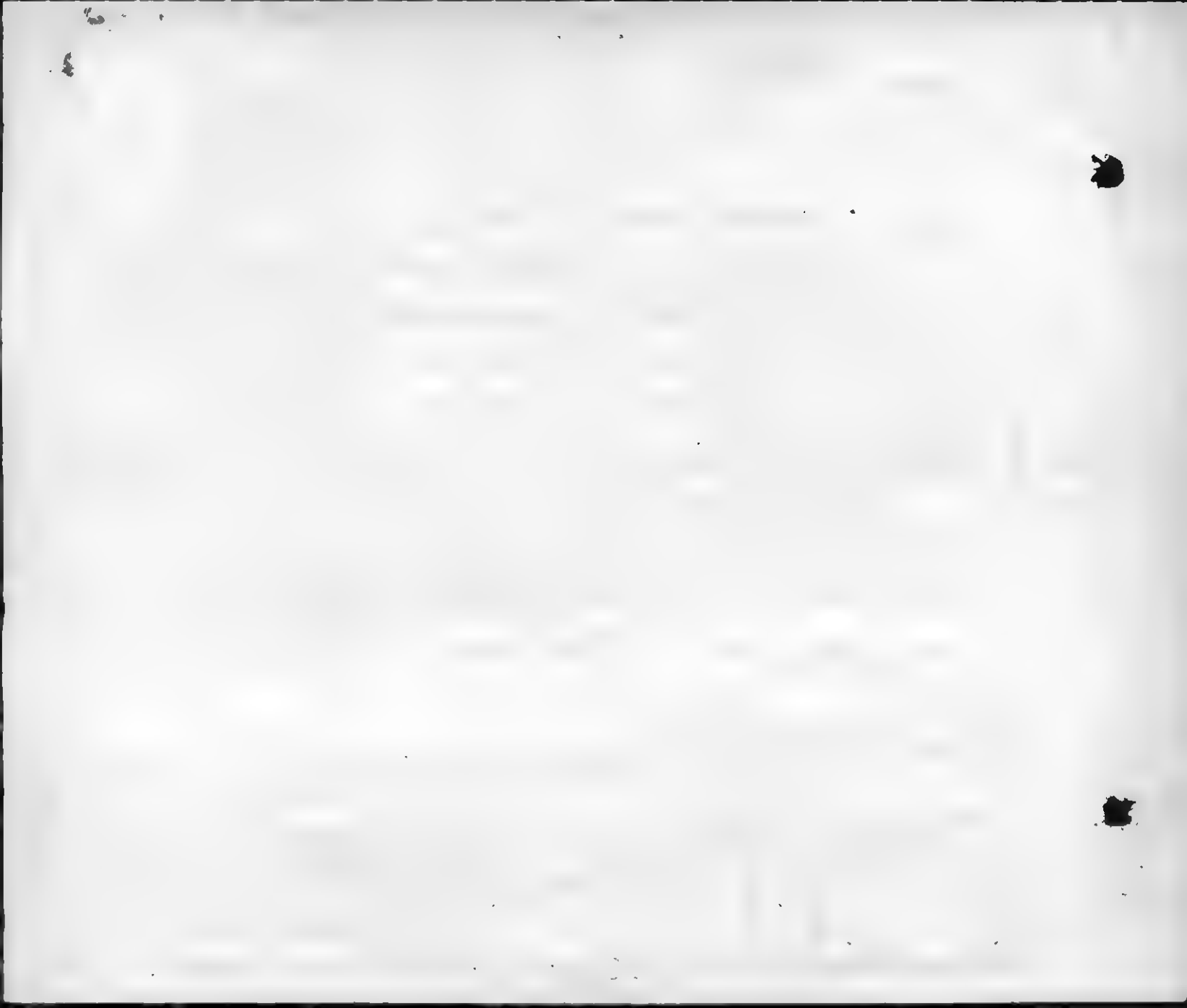
11188

11164

Reg. Dist. No.

1. PLACE OF DEATH, o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>3 MOS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>229 E. Main Street</u>				d. STREET ADDRESS <u>229 E. Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E.</u> Last <u>Sandbower</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/15/1879</u>		9. AGE (In years last birthday) <u>79</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meth. Min.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Sandbower</u>				14. MOTHER'S MAIDEN NAME <u>Anne Le Gaud</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Son - Mr. Sandbower</u>		Address <u>229 Westminster Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>about 1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u>58</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>Oct 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 24</u> , 19 <u>58</u> , and that death occurred at <u>9:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>854 W. Green St Westminster Md</u> DATE SIGNED <u>10/24/58</u>							
ACTUAL SIGNATURE <u>Julius Chapko</u> M.D.				DATE SIGNED <u>10/24/58</u>			
PHYSICIAN'S NAME (Type) <u>Julius Chapko</u>				ADDRESS <u>Westminster Md</u>			
22a. MARRIAGE, CREMATION, OR BURIAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Md</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Luigi Steinhilber</u>				24. REC'D BY REGISTRAR <u> </u> DATE <u>OCT 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11198

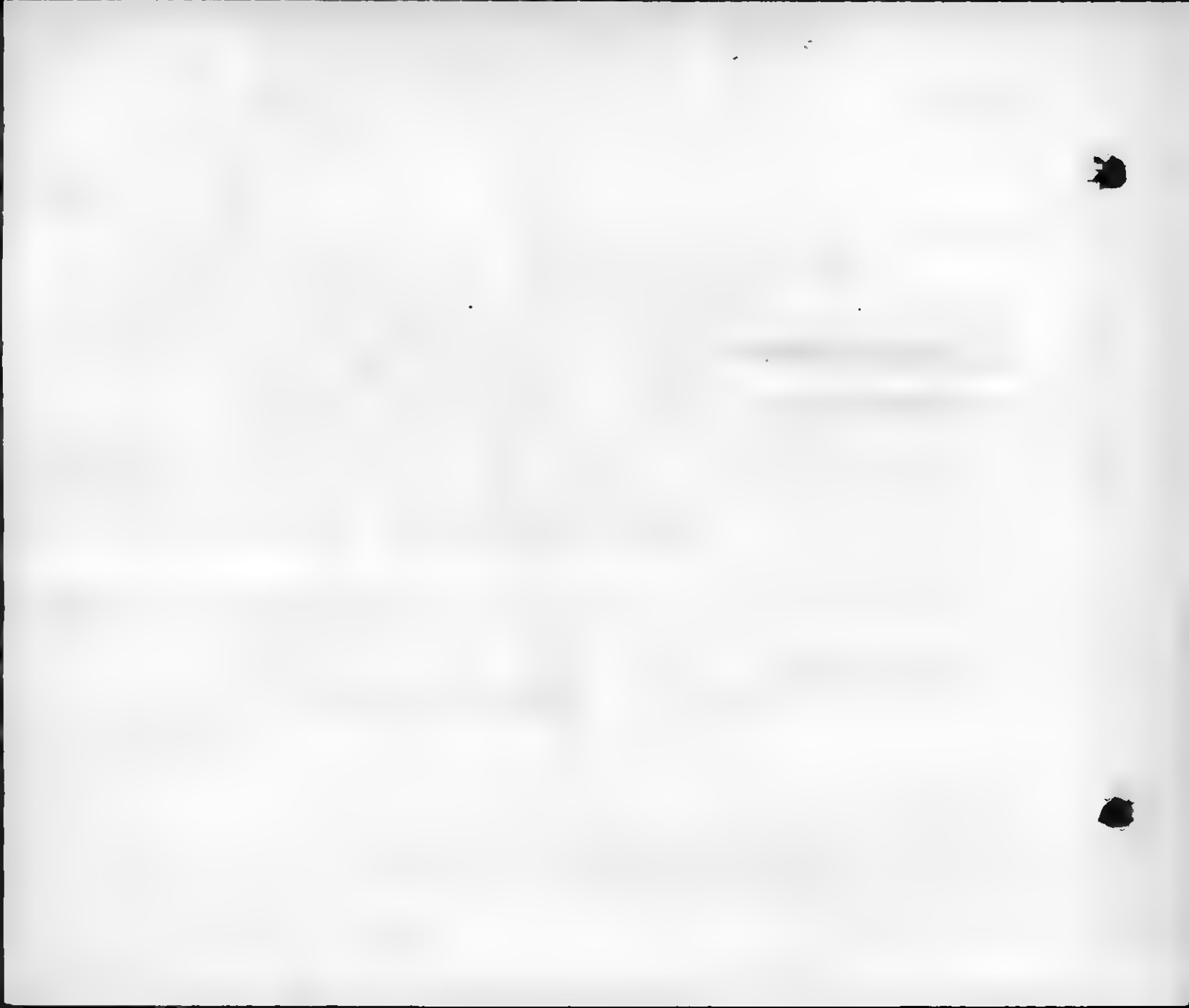
CERTIFICATE OF DEATH

11189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
c. LENGTH OF STAY IN 1b <u>4 years</u>				d. STREET ADDRESS <u>Westminster RD #2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster Md. RD #2</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTINE ANNA SCOTT</u>				4. DATE OF DEATH Month Day Year <u>Oct. 31 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1877</u> 77? yrs		9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Swedish board operator hotel</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Morrisville, N.Y.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Napoleon Rock</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Sorrell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>216-03-9822</u>				17. INFORMANT <u>Mr. R. P. Hahn, Westminster Md RD #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>A.S.C.V. disease & Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 31 1958</u> to <u>Oct 31 1958</u> , that I last saw the deceased alive on <u>Oct 31 1958</u> , and that death occurred at <u>10:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>11/1/58</u>							
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.				PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u> <u>Westminster Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 4. 58</u>		<u>New Catholic Cemetery</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr.</u> ADDRESS <u>Westminster Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carl G. Hahn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11190

Reg. Dist. No. _____

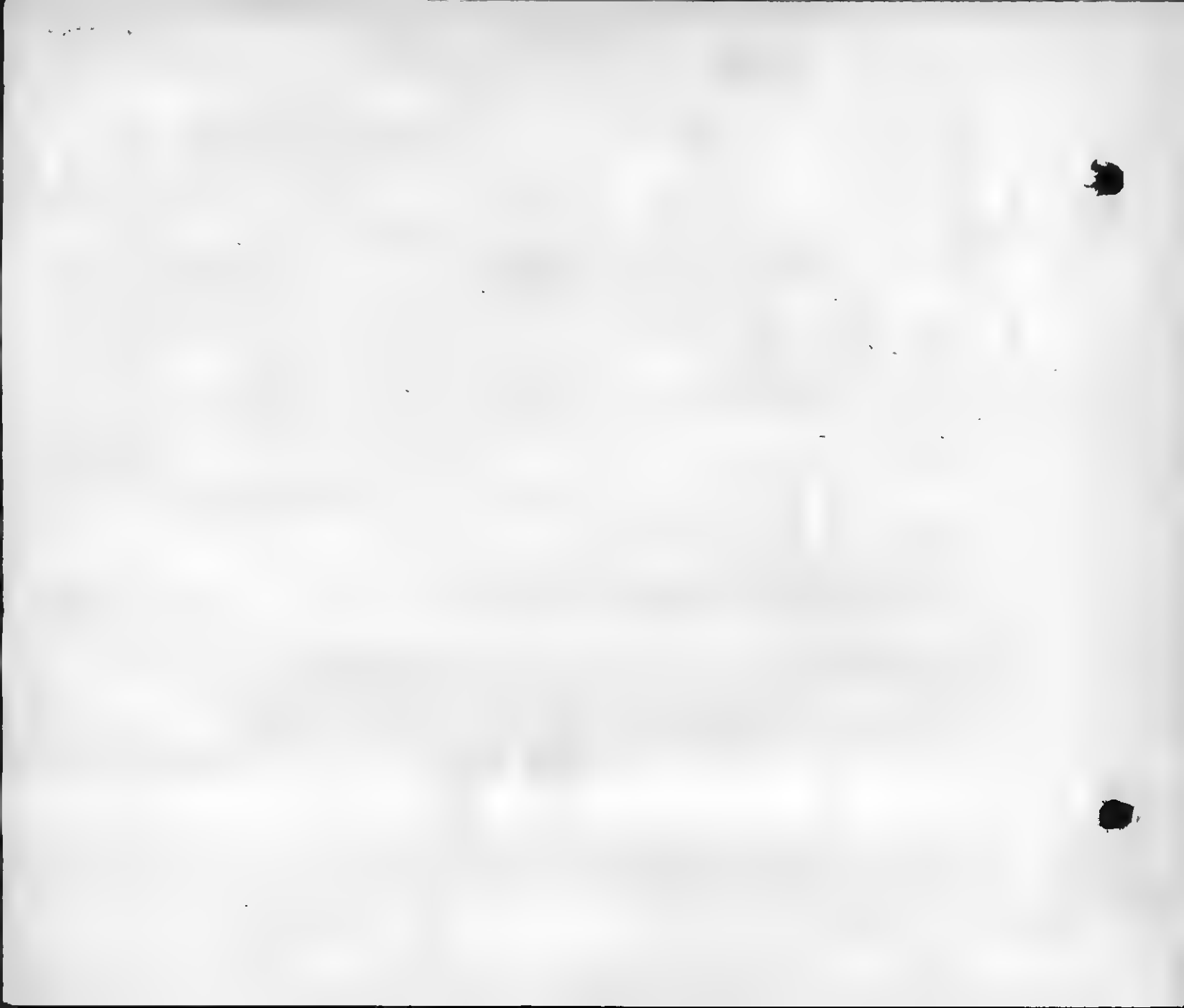
11165

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55



11199

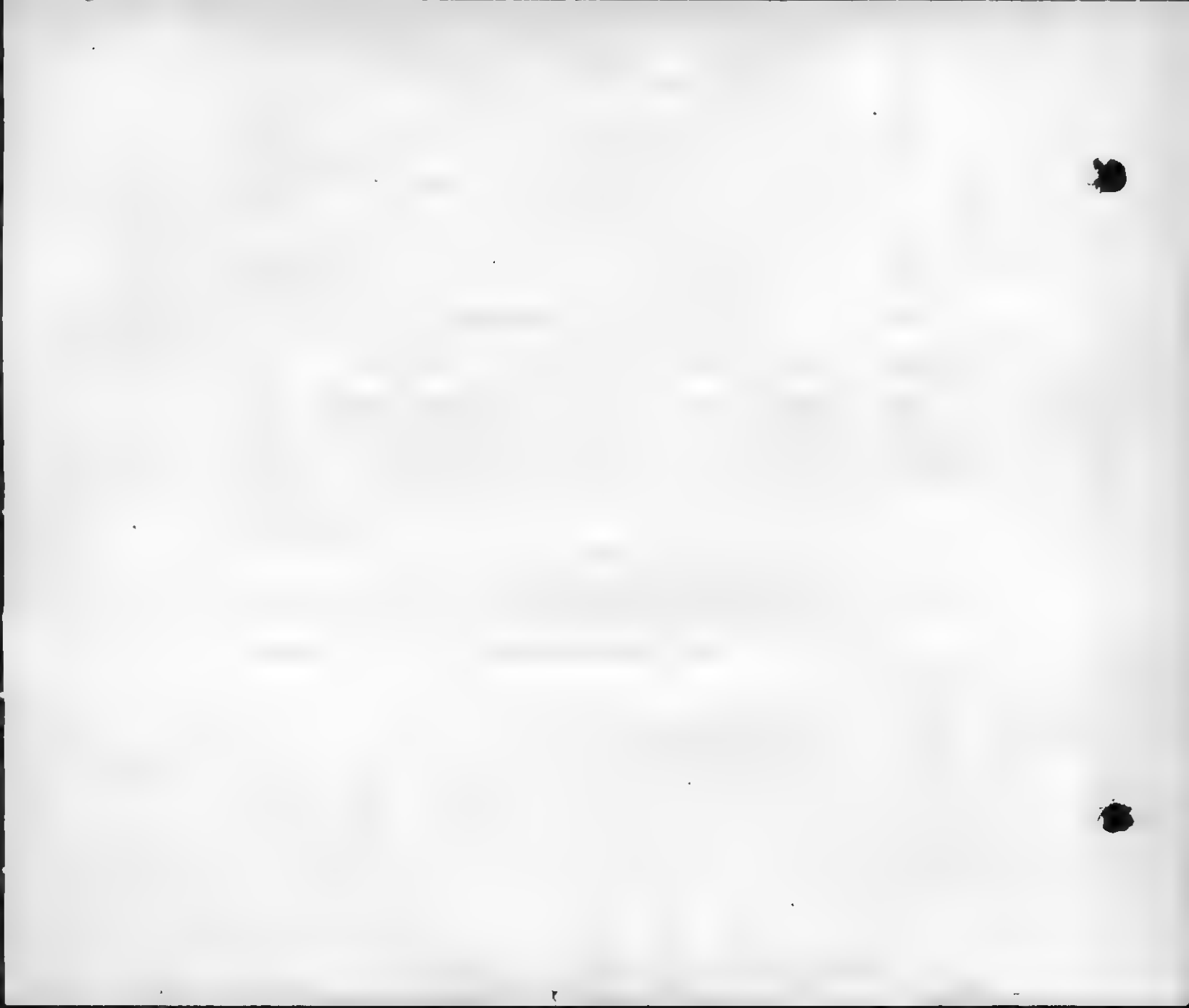
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>Cabland Road</i>	
3. NAME OF DECEASED (Type or print) <i>SADIE</i> First Middle Last		4. DATE OF DEATH <i>Oct. 14</i> 1958 Month Day Year	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 4, 1919</i>
9. AGE (In years - lost birthday) <i>39</i> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Steven</i>		14. MOTHER'S MAIDEN NAME <i>Anna Harvey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>W</i>		16. SOCIAL SECURITY NO <i>213-12-6284</i>	
17. INFORMANT <i>Mr. Howell Shipley</i> Address <i>Sykesville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma heart, metastatic to</i> DUE TO <i>brain, lumbar vertebrae, pelvis, ureters</i> Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Simian Cardiac arrest</i> (b) <i>Simian Cardiac arrest</i> (c) <i>Simian Cardiac arrest</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1958</i> <i>to 4 Oct 58</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1956</i> 19 <i>14 Oct</i> 1958, that I last saw the deceased alive on <i>14 Oct</i> 1958, and that death occurred at <i>11: P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.		ADDRESS (Street, city or town, state) <i>Sykesville, Md.</i> DATE SIGNED <i>4 Oct 58</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		<i>SYKESVILLE, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>10-18-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bethesda</i>	22d. LOCATION (City, town) or county (State) <i>Sykesville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Thigley</i> Address <i>Sykesville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 21 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur A. Thigley</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

CERTIFICATE OF DEATH

11192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ROUTE #6 WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MURRAY ROBERT STEM JR</u>				4. DATE OF DEATH Month Day Year <u>OCTOBER 8th 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 11, 1919</u>		9. AGE (In years last birthday) <u>39</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MURRAY ROBERT STEM SR.</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL ANNA TARBART</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-26-0364</u>		17. INFORMANT Address <u>WIFE MAY E. WANTZ STEM (SAME) ADDR-SS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Original site - Prostate</u> DUE TO (c) <u>10 mo.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 31, 1957</u> , to <u>10/8/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/7/58</u> , 12 <u>00</u> , and that death occurred at <u>4:55 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>New Windsor Md. 10/8/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 11, '58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORSVILLE M.C.M.</u>		22d. LOCATION (City, town, or county) (State) <u>TAYLORSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Sapp</u>				ADDRESS <u>234 E Main St. Westminster Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			



11201

CERTIFICATE OF DEATH

Reg. Dist. No. 11193

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Manchester</u>	
c. LENGTH OF STAY IN TB <u>17 yrs</u>		d. STREET ADDRESS <u>Manchester P.O. #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Manchester P.O. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LIZZIE</u> Middle <u>BLACK</u> Last <u>STERNER</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>11</u> Year <u>1958</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Black</u>		14. MOTHER'S MAIDEN NAME <u>Franca Kemerod</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Miss Ester Sterner Manchester Md.</u>		Address <u>Manchester Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> <u>470.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Liver Cirrhosis; Simple goiter; Direct and indirect hernia; diabetes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>260X</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>43</u> , to <u>10-10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/9/</u> , 19 <u>58</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED <u>10.13.58</u>			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		Hampstead, Md.	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		Hampstead, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 14 1958</u>	<u>Manchester Md.</u>	<u>Manchester Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. R. Co.</u> ADDRESS <u>W. R. R. Co.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 15 58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER RURAL		c. LENGTH OF STAY IN 1b 5 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GLYERS NURSING HOME		d. STREET ADDRESS BENEDUM ST.	
3. NAME OF DECEASED (Type or print) SADIE ELIZABETH STONESIFER		4. DATE OF DEATH OCT 20 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 1 - 1867
9. AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN BROWN		14. MOTHER'S MAIDEN NAME MARY JANE BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO		16. SOCIAL SECURITY NO (If yes, give war or dates of service) NONE	
17. INFORMANT POLOD STONESIFER		Address UNION BRIDGE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple cerebral thromboses DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) extensive decubitus ulcers		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1958 , to Oct 20, 1958 , that I last saw the deceased alive on Oct 20, 1958 , and that death occurred at 6:17 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Reese Wilkens M.D.		DATE SIGNED 10/21/58	
PHYSICIAN'S NAME (Type) E REESE WILKENS		ADDRESS (Street, city or town, state) Westminster, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/22/58	
22c. NAME OF CEMETERY OR CREMATORY LUTHERAN		22d. LOCATION (City, town, or county) (State) TANEY TOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE W D Hartsler & Sons Union Bridge		ADDRESS	
24a. REC'D BY REGISTRAR DATE OCT 23 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11203

CERTIFICATE OF DEATH

11195

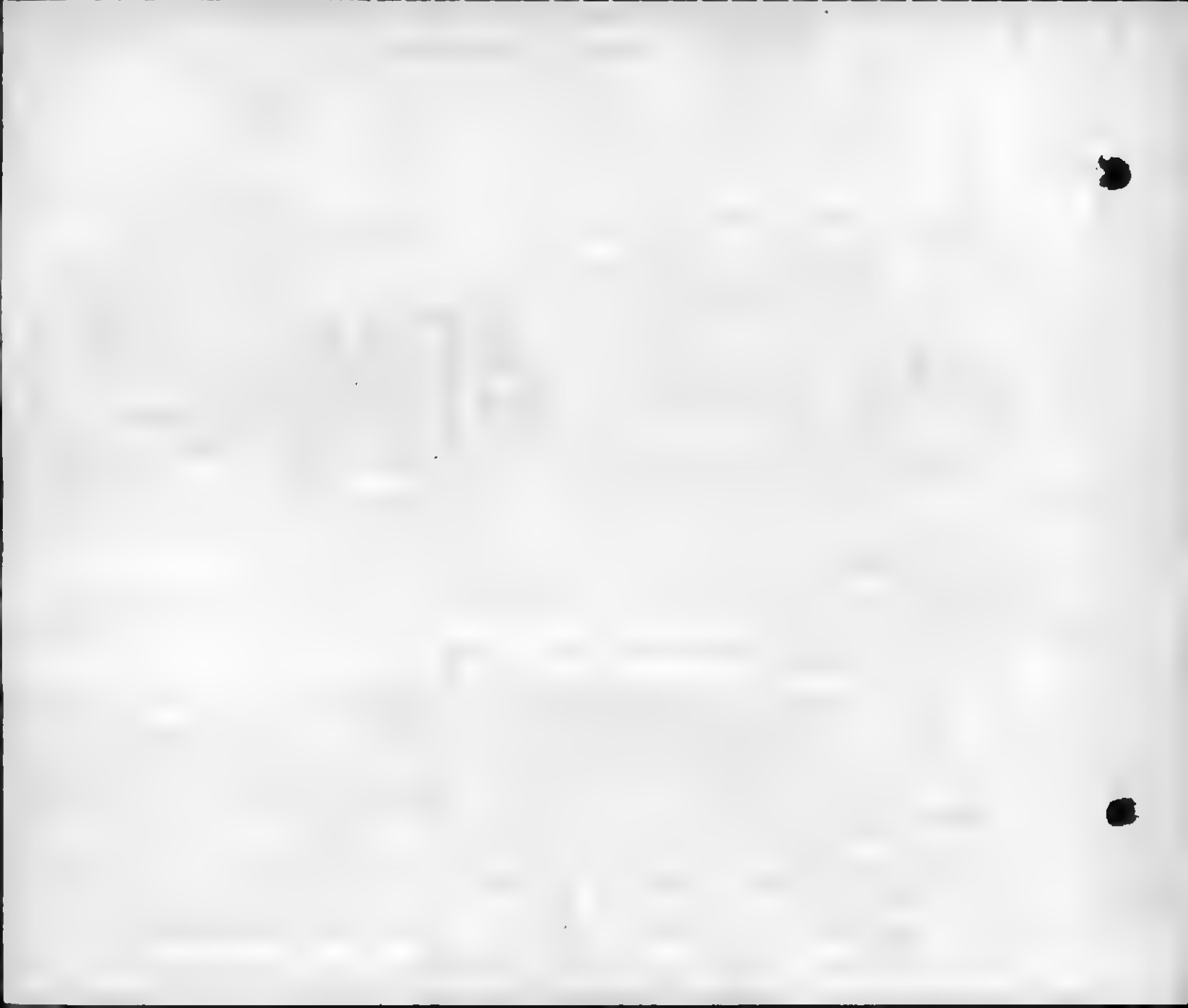
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster #3</u>		c. CITY OR TOWN (If inside corporate limits, write RURAL and give nearest town) <u>Westminster #3</u>	
c. LENGTH OF STAY IN 1b <u>74 days</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Irene Stremmel</u> First Middle Last		4. DATE OF DEATH <u>Oct 27</u> Month Day Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/1958</u>
9. AGE (In years last birthday) yrs <u>2</u> Months <u>14</u> Days <u></u> Hours <u></u> Min <u></u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster #3</u>	
11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gerard Henry Stremmel</u>		14. MOTHER'S MARRIED NAME <u>Kola Mae Helsky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Gerard Stremmel Westminster #3</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>measles - pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Oct 26 -</u> <u>his Oct 27 -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 13</u> , 1958, to <u>Oct 27</u> , 1958, that I last saw the deceased alive on <u>Oct 26</u> , 1958, and that death occurred at <u>1:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George P. And</u> M.D. <u>139 Conville St</u>		DATE SIGNED <u>Harmon Pa</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/28/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Block Rock</u>	22d. LOCATION (City, town, or county) (State) <u>Block Rock & York Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Buckner, Funeral Co</u> ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>George P. And</u>
DATE <u>OCT 28 1958</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

Items 20&21 fill in MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
235 11-17-58 am

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11196

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 2yrs. 8mos. 5days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Severn d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) First Jeannette Middle Griffith Last Taylor		4. DATE OF DEATH Month October Day 19 Year 1958	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1879	
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR: Months --- Days --- Hours --- Min ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Columbus Griffith		14. MOTHER'S MAIDEN NAME Emily Griffith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Springfield Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to cause other than trauma 921.7 DUE TO Choked on Piece of cake Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involuntional psychotic reaction. Pulmonary tuberculosis.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Patient choked on a piece of cake.	
20c. TIME OF INJURY Month, Day, Year 4:15 p.m. Oct 19-1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work Springfield State Hosp.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hosp.		20f. (City or town) Carroll (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. W. Glenn Speicher		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE THEREOF 10/19/58		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/58	
22c. NAME OF CEMETERY OR CREMATORY Friendship		22d. LOCATION (City, town, or county) Anne Arundel Co. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Karkley, Glen Burnie, Md		24a. REC'D BY REGISTRAR Arthur S. Huns	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns		DATE OCT 23 '58	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11197

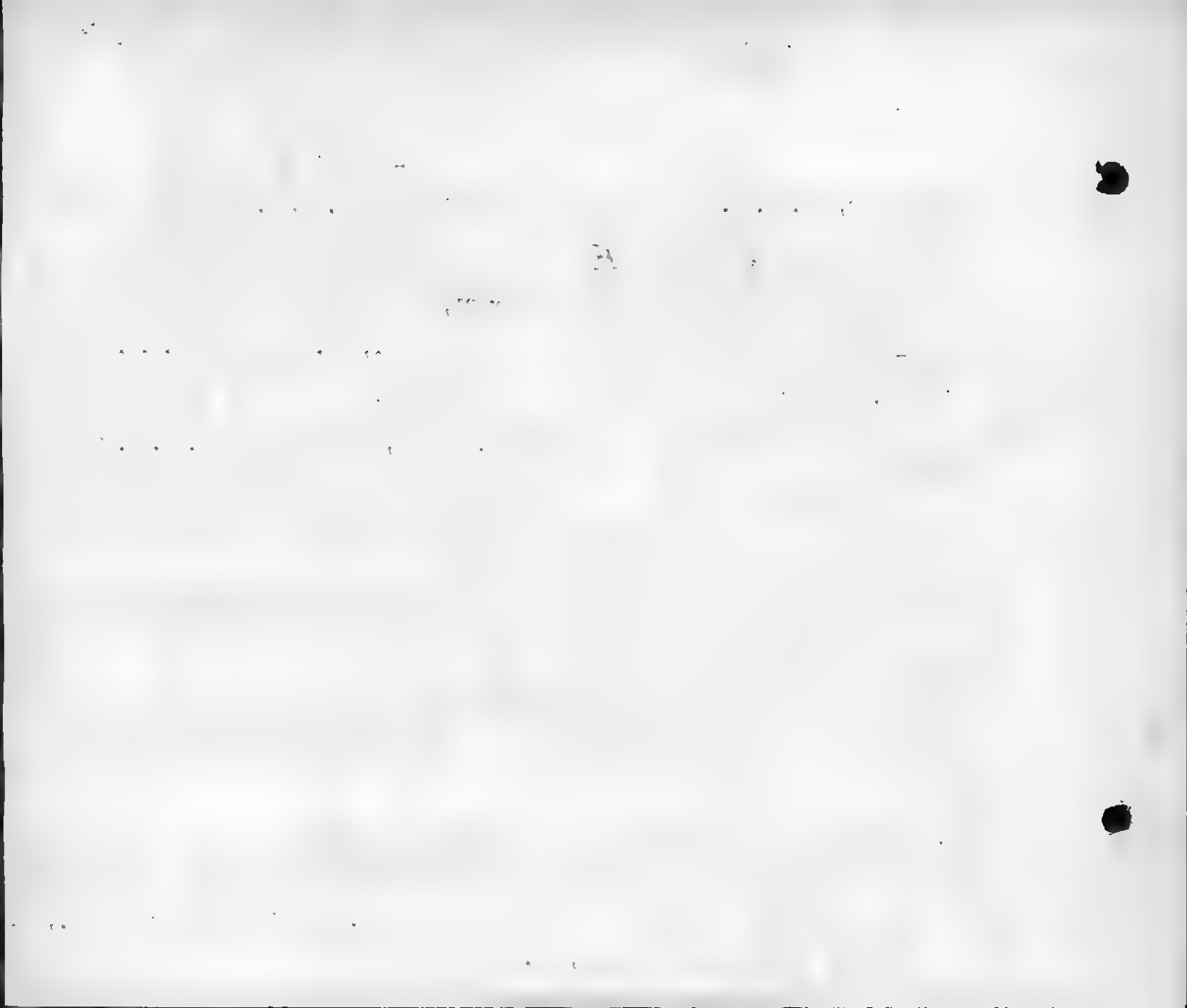
11205

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut an. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Westminster</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster, Md. R. D. 2</u>		d. STREET ADDRESS <u>Westminster, Md. R. D. 2</u>	
3. NAME OF DECEASED (Type or print) <u>GOLDIA BELLE WAGNER</u>		4. DATE OF DEATH <u>Oct 12 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elias G. Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Pickett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Paul W. Wagner</u> Address <u>Paul W. Wagner, Westminster, Md. R. D. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10/12/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Westminster, Carroll Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u> ADDRESS <u>Littlestown, Pa.</u>		24a. REC'D BY REGISTRAR <u>Oct 14 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>John S. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11198

11166

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN lb <u>2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				e. STREET ADDRESS <u>141 Bishop Ct</u>			
3. NAME OF DECEASED (Type or print) <u>REBECCA - A - WAGNER</u> First Middle Last				4. DATE OF DEATH <u>Oct 4 - 1958</u> Month Day Year			
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 - 1863</u>	9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah Leppo</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Aubough</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>720</u>		17. INFORMANT <u>Mrs Chas Maucha - Westminster Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x cerebral thrombosis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>unknown</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 30, 1958</u> to <u>Oct 4, 1958</u> , that I last saw the deceased alive on <u>Oct 2, 1958</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemper av. Westminster Md</u> DATE SIGNED <u>md 58</u>							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u>				PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct 7 - 1958</u>		<u>Wesley</u>		<u>Carroll co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Chpton</u> ADDRESS <u>Newport Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1117

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

CERTIFICATE OF DEATH

1118

[Faint, mostly illegible handwritten text on a death certificate form. The form includes fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Place of Death. The handwriting is very light and difficult to decipher.]

11206

CERTIFICATE OF DEATH

11199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 40 y. 2 m. 2d. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 21032 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Henry Newton Wishard				4. DATE OF DEATH Month Day Year October 24 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Wishard			14. MOTHER'S MAIDEN NAME Rebecca Holbrenner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002X (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. Pulmonary tuberculosis, far advanced, active.						INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 10/20/54 , 19 54 , to 10/24/58 , 19 58 , that I last saw the deceased alive on 10/24/58 , 19 58 , and that death occurred at 3:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <i>Julian Radzykewicz</i>		M.D. Springfield State Hospital 10/24/58					
PHYSICIAN'S NAME (Type) Julian Radzykewicz, M.D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 28, 1958	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Marlin Poe</i>			ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR DATE OCT 27 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01/04/2017 09:10:30

Page 10 of 10